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INSTRUCTIONS FOR COMPLETING THE ADJUSTED COMMUNITY RATE PRICING FORM FOR CONTRACT YEAR 2004

Contents

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Introduction

Each Medicare+Choice (M+C) organization must compute a separate adjusted community rate (ACR) for each M+C coordinated care, private fee-for-service, or religious fraternal benefit plan it offers to Medicare beneficiaries. The ACR computations must be made and submitted to the Centers for Medicare and Medicaid Services (CMS) on its ACR forms.

In addition to the ACR calculations, M+C organizations (M+COs) must give CMS additional supporting material. All data submitted as part of the ACR process are subject to audit by CMS or any person or organization that CMS designates.

CMS provides both paper and electronic ACR forms for M+COs to use. ACR forms for contract year (CY) 2004 have revisions to address problems that surfaced during the CY 2003 Adjusted Community Rate Proposal (ACRP) process, as well as changes required by law and CMS policy. The revised forms are consistent with the requirements of Title XVIII of the Social Security Act (as amended) and related CMS rules and regulations.

To compute ACRs for CY 2004, M+COs will need to complete a series of calculations and enter the results on the appropriate ACR worksheets. The number and type of calculations depend on several factors such as the type of plan, how long it has operated, and whether the sponsoring M+CO has non-Medicare enrollees in the same type of plan.

The following describes the most common type of ACR calculation for CY 2003.It involves the proposed renewal of an M+C plan that has been operating for at least 2 years under an M+C contract and the sponsoring M+CO had non-Medicare enrollees in the same type of plan. One step is to report collections (on an accrual basis) from non-Medicare enrollees in the base period (i.e., the year beginning 2 years before the contract year). M+COs must report the collections in total and in terms of the components shown on the worksheets. A related step is to calculate a non-Medicare initial rate (and break out specific components of it) for the contract year. The initial rate represents the average rate (including both premiums and cost sharing) that the M+C organization would charge to all non-Medicare enrollees that it expects to have enrolled in the same type of plan as the M+C plan priced in the ACR for 2004. The electronic version of the ACR worksheets compares the initial rate (and selected components) that an M+C organization projects for 2004 to the base-period collections (and selected components) from M+C organization enrollees to produce 2-year non-Medicare trend factors. The M+CO also must report the Medicare base period costs and cost offsets on another worksheet. The ACR worksheets apply the trend factors to base-period Medicare costs and to offsets thereby producing an estimate of Medicare costs and offsets for the contract year. The worksheets permit

M+COs to adjust the estimates when necessary. In addition, to the ACR calculation, M+COs must provide other information such as monthly premiums and the per-member-per-month values for any cost sharing they intend to charge members enrolled in the plan.

M+C organizations that did not have non-Medicare enrollees in the base period or do not expect to have them in the contract year should refer to the special instructions in the discussions of individual ACR worksheets. M+C organizations completing ACRs for plans with no Medicare enrollees in the base period also should refer to the special instructions in the discussions of individual ACR worksheets.

An M+C organization may contract with CMS to offer several M+C plans, including coordinated care plans (e.g., health maintenance organizations [HMOs], preferred provider organization [PPO] plans); religious fraternal benefit plans; and private fee-for-service (PFFS) plans. Each type of M+C plan would have its own service area. M+C benefit packages offered under the various M+C plans could have different Additional Benefits, Mandatory Supplemental Benefits, Optional Supplemental Benefits, and pricing structures.

Each M+C plan that an M+C organization offers must contain a specific set of benefits at the same price to every Medicare beneficiary throughout the plan's service area. The M+C plan offered to Medicare beneficiaries must contain all items and benefits covered under original Medicare (except hospice care) and any required Additional Benefits. The M+C organization can offer (if CMS agrees) Mandatory Supplemental Benefits as part of the specific set of benefits. Finally, the M+C organization can augment its plan with Optional Supplemental Benefits that Medicare beneficiaries can purchase at their option. M+COs must offer each M+C plan and its associated Optional Supplemental Benefits throughout the service area of the M+C plan.

M+C organizations must use the CMS ACR forms to develop a pricing structure for each M+C plan. Organizations must submit the information in the CMS-approved electronic format. In addition, M+COs must submit a paper copy of the completed ACR containing a signed certification on Worksheet A. The Office of Management and Budget (OMB) has approved the ACR format and has determined that the worksheets are necessary for the government's efficient operation and that they do not impose an unnecessary paperwork burden on M+C organizations.

An M+C organization must submit these forms in accord with the schedule in Chapter 8 of the CMS *Medicare Managed Care* (MMC) *Manual*. The MMC Manual is posted on the CMS website at http://www.cms.hhs.gov/healthplans.

Each M+C organization must submit a separate ACR proposal for each M+C plan that the organization intends to market in a given service area. Because M+C plans covering Part B-only enrollees are separate from M+C plans serving enrollees eligible for both Part A and Part B of Medicare, organizations generally must submit separate ACR forms for any M+C plans covering Part B-only Medicare enrollees. See sections 70 and 130 of Chapter 8 of the MMC Manual.

ACR approval will take place so that both CMS and M+C organizations can send information to Medicare beneficiaries before the open enrollment period begins (around November of each year).

If you have any questions about the content of the ACR worksheets, please e-mail them to CMS at ACR@cms.hhs.gov.

What's New for the CY 2004 ACR?

The ACR pricing forms and related instructions have the following changes for CY 2004:

- All worksheets that permit data entry will reject copied data (or data imported by means of links users make to their own worksheets) that does not meet the verification tests built into the worksheet. Error messages will warn users when data does not meet the verification test. Such error will preclude uploads to HPMS.

- Worksheet A (Cover Sheet)

  - Part IA will allow M+C organizations to indicate whether they submitted an actuarial certification with the ACRP. The instructions now discuss actuarial certifications.

  - Part IB (Non-Medicare Cost Information) has new lines to display separately any reinsurance premiums and reinsurance recoveries in the base period and in the contract year. The worksheet will calculate a trend value for reinsurance premiums and recoveries.

  - Part III has been redesigned for 2004. Values for Optional Supplemental Benefits will not appear on the 2004 form but values for basic benefits and mandatory supplemental benefits will appear separately.

  - For contract year 2004, the actuarial value of the fee-for-service Medicare deductible and coinsurance amount for all counties is $113.34 PMPM for Part A/B enrollees and $84.51 PMPM for Part B-only enrollees. These values appear in the CMS letter *Announcement of Calendar Year 2004 Medicare+Choice Payment Rates*, dated May 12, 2003.

  - The former section on M+C MSAs has been deleted. Under section 1851(b)(4)(A) of the Social Security Act, …an individual is "…not eligible to enroll in an MSA plan under this part—(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date…" Because no one was enrolled in an MSA plan as of that date, no one can be enrolled in one after January 1, 2003.

  - Your M+CO's vice president for marketing (or equivalent) will not have to sign the ACR certification in 2004.

- Worksheet A1 (Service Area and Estimate of Annual Payment Rate)

  - The worksheet will allow for the statutory change in the phase-in of risk adjustment of payment rates for 2004. The payment rates for 2004 will reflect 70 percent demographic factors and 30 percent risk adjustment.

- The worksheet will allow for the effects on payment rates of implementing a new comprehensive risk adjustment method (the CMS Hierarchical Condition Category model).

♦ Worksheet B (Base Period Costs and Enrollment)

- Benefits from reinsurance policies (reinsurance recoveries) will appear as a separate line on the worksheet, within the category of direct medical costs.
- Direct medical costs on lines 1-19 will not include reinsurance recoveries in 2004.
- Reinsurance policy premiums will appear as a separate line on the worksheet for 2004.
- Base-period costs will reflect the base-period service area of the plan priced in the ACR. Previously, CMS asked M+COs to adjust the base-period costs to reflect the contract-year service area of the plan.
- Prior CMS approval of component grouping methodology is no longer required, but inclusion of a detailed description of the grouping methodology is.

♦ Worksheet D (Expected Cost and Variation for the Standard Benefit Package)

- Benefits from reinsurance policies (reinsurance recoveries) will appear as a separate line on the worksheet, within the category of direct medical costs.
- Direct medical costs on lines 1-19 will not include reinsurance recoveries in 2004.
- Reinsurance policy premiums will appear as a separate line on the worksheet for 2004.
- Expected variations will be needed on Worksheet D to adjust trended values for plans having a contract-year service area that is different from the base-period service area. This is consistent with the Worksheet B instructions that require base-period costs to reflect the plan's base-period service area.

♦ Worksheet E (Adjusted Community Rate for the Standard Benefit Package) will have additional lines to display the contract year 2004 values for any reinsurance premiums and recoveries.

♦ Worksheet F (Adjusted Community Rate, Premiums, and Cost Sharing for Optional Supplemental Benefits): Expected variations will be needed on Worksheet F to adjust trended values for plans having a contract-year service area that is different from the base-period service area. This is consistent with the Worksheet B instructions that require base-period costs to reflect the plan's base-period service area.

- Worksheet G (Actuarial Review Sheet) is a new form for CMS use that displays various calculations using data from other ACR worksheets. You will not have to enter any data directly on Worksheet G.

Other changes to the ACR instructions:

- Some of the material formerly in the ACR instructions is now located in Chapter 8 of the CMS MMC Manual. Examples of material now in the MMC Manual include the definitions and the specialized chapters (Chapters 11-16) from the ACR instructions for CY 2003. Some of these specialized chapters have been extensively re-written for clarity, so we suggest reviewing them in the MMC Manual before completing your 2004 ACR. A crosswalk is provided below for ease of reference:

  - The definitions that appeared before Chapter 1 of the 2003 ACR Instructions now appear in Section 20 of Chapter 8 of the MMC.

  - Chapter 11 (Enrollees Electing Hospice) of the 2003 ACR Instructions became Section 100 of Chapter 8 of the MMC.

  - Chapter 12 (Enrollees with ESRD) of the 2003 ACR Instructions became Section 110 of Chapter 8 of the MMC.

  - Chapter 13 (User Fees) of the 2003 ACR Instructions became Section 120 of Chapter 8 of the MMC.

  - Chapter 14 (Waivers to Facilitate M+CO Contracts with Employer or Union Groups) of the 2003 ACR Instructions became Section 130 of Chapter 8 of the MMC.

  - Chapter 15 (Coordination of Benefits) of the 2003 ACR Instructions became Section 140 of Chapter 8 of the MMC.

  - Chapter 16 (Stabilization Funds) of the 2003 ACR Instructions was incorporated into Section 80 of Chapter 8 of the MMC.

Chapter 1. General Instructions

M+C organizations must submit their annual renewal information (premium and M+C plan documentation) covering the contract period January 1, 2004 through December 31, 2004 by September 8, 2003.

Submit one ACR proposal for each M+C plan that an M+C organization intends to market in the service area in its M+C contract. (In addition, if your organization segments a service area, submit a separate ACR for each plan in each segment.) Organizations with both Part A/B Medicare enrollees and remaining Part B-only Medicare enrollees generally must have separate M+C plans for each of those two groups. (See the subsection below titled "Part B-Only Enrollees and ACRs**.")**

In order for CMS to approve an ACR proposal in a timely manner, the proposal must be filed as early as possible, must be in a format acceptable to CMS, and must contain back-up data to support certain figures and computations. If you do not have enough enrollment experience to develop data, you may use appropriate projection techniques that are generally acceptable throughout the health care industry.

CMS reviews all ACR proposals. CMS reviewers might request additional information about or clarification of submitted data. In some instances, CMS reviewers might have to ask for certain information before completing their full review of an ACR. M+C organizations need to respond promptly to requests from CMS. The approval of an ACR proposal can be delayed if CMS has to request additional documentation. To avoid unnecessary delays and speed up the review process, follow the guidelines listed below (and any supplemental guidelines that CMS issues) when preparing your ACR proposal.

Please observe the following guidelines to ensure timely review of your ACR:

- Show clearly in the ACR proposal per member, per month (PMPM) values for all cost sharing listed in the plan benefit package (PBP) for the M+C plan.

- Remember that a plan can have only one premium, one cost-sharing structure, one set of Additional Benefits and one set of Mandatory Supplemental Benefits. You can vary those elements as long as you create a separate plan with its own ACRP for each distinct group of variations.

- Plans that are identical except for different Optional Supplemental Benefits are not allowed. Instead, offer one plan with different Optional Supplemental Benefits.

- Display all recoveries from reinsurance contracts on a separate line provided on relevant worksheets. Do not include reinsurance recoveries in any other lines under direct medical costs on the same worksheets.

- Include user fees (e.g., information campaign user fee) in the costs of administration, if you include them at all on your ACR. Otherwise, if you do not show them as revenue, then you do not need to show them as administrative costs.

- Display reinsurance premiums as a separate category on the relevant worksheets.

- Use medical benefit categories (health care components) set forth on the lines of certain ACR worksheets. The Administration and Additional Revenue components must contain plan data when you submit your ACR.

  - With respect to Worksheet B (base-period costs), you may group data for health care components—other than Point-of-Service (POS), Administration, and Additional Revenue—that your accounting system will not break out. If you must group the data for different health care components, please follow the directions for grouping in the 2004 ACR Transmittal Instructions.

  - Do not group data required for health care components on Worksheets C and F. However, you may be permitted to group health care components on Worksheet D using the same grouping methodology you used on Worksheet B. Please follow the directions for grouping in the 2004 ACR Transmittal Instructions.

  - Do not group data required for the statutory benefit categories (columns) on Worksheets B, C, and D.

- Organize all back-up data by worksheet. Additional, detailed instructions for sending the ACR and supporting material to CMS will be available separately.

- Group medical benefits included in specific categories consistently from year to year.

- Display your M+CO's H-number clearly in the cover letter and in all subsequent correspondence with CMS.

- If your CY 2004 contract reduces the previous year's service area (e.g., deletes an entire county of a plan) or changes the service area of a plan so that at least one payment area (e.g., county, parish) is reduced, review Part III, Section 1, of the 2004 Call Letter. Call your plan manager to discuss the effects of the change on plan enrollees if you have any questions.

Back-Up Material/ACR Documentation

Refer to the CMS ACRP Transmittal Instructions (under separate cover) for more on specific items of back-up material you will need to submit to CMS with your ACRP. Retain the back-up material you submit and other material related to your ACR for a period of six years. Your M+CO must make material related to its ACRs and M+C contract available to the Department of Health and Human Services (HHS), the Comptroller General, or their designees for audits and other purposes. In addition, your M+CO **must** notify all related entities, contractors, and

subcontractors that HHS, the Comptroller General, or their designees have the right to access such material. For more on these matters, see section 70, Chapter 8 of the MMC manual, section 110, Chapter 11 of the MMC manual, and 42 CFR 422.502.

Part B-Only Enrollees and ACRs

A Medicare beneficiary with Medicare coverage only under Part B cannot elect an M+C plan after December 31, 1998, unless they are members of employer or union groups.

However, a Medicare beneficiary (with Part B coverage under Medicare) who was a Medicare enrollee of a Section 1876 contractor on December 31, 1998, shall be considered to be enrolled with that organization on January 1, 1999, if the organization had an M+C contract for providing benefits on the latter date. Health benefit coverage that M+C organizations provide to such remaining Part B-only enrollees constitutes a separate M+C plan (which requires a separate ACR proposal).

CMS encourages M+C organizations to submit as few plans as possible for its pre-1999 Part B-only members, rather than duplicating each of its A/B plans for them. In fact, an M+C organization can submit one plan for all its pre-1999 Part B-only members under an M+C contract if they are in the same type of plan. In addition, if you offer your pre-1999 Part B-only members the same benefits as A/B members (i.e., members eligible for both Part A and Part B of Medicare) for the same price that you charge to A/B members, you are not required to submit a separate ACR for the Part B-only members.

On the other hand, M+COs that enroll Medicare beneficiaries with Part B-only coverage in an employer-only or union-only plan must prepare a Part B-only ACRP. Failure to create a separate B-only plan will result in the rejection of any enrollments submitted on behalf of individuals without Part A by the CMS managed care payment system.

Prepare Part B-only ACRs in much the same way as you would prepare an ACR for Part A/B members. These instructions discuss the differences in ACRs for the Part A/B and Part B-only plans in the appropriate chapters.

Accounting Considerations

Except as provided in the next paragraph, M+C organizations must have an adequate accounting system that is accrual-based and must use generally accepted accounting principles (GAAP) to develop ACRs.

For organizations that are part of a government entity using a cash basis of accounting, ACR cost data developed on that basis is acceptable. However, only depreciation on capital assets, rather than the expenditure for the assets, is acceptable for ACR costing purposes.

Relationship of the ACR Pricing Form to the Plan Benefit Package Form

M+C organizations must submit a PBP with each ACR. The two documents together constitute an ACRP for an M+C plan. Unlike the ACR, the PBP exists only as an electronic document—there is no paper version of it. Instructions for completing the PBP worksheet are available separately from CMS.

Benefits, premiums, and cost-sharing values in the PBP must be consistent with corresponding values in the ACR. For example, PMPM calculations for cost-sharing values on Worksheet C for a specific benefit (i.e., health care component) must use the cost sharing amounts in the PBP for that benefit.

Relating the data in the two documents is relatively easy, because the PBP groupings of individual health care benefits have the same names as the health care components of the ACR. For example, when your plan includes any of the preventive benefits that are shown under the PBP category called "Preventive Services" (category 14), then you also need to include the costs for those benefits on the Preventive Services line of your ACR.

ACR Electronic Worksheets and Database

CMS will provide ACR forms to you in Excel format. Send both paper copies and electronic copies of the ACR forms, with all required back-up material, to CMS by the due date. Electronic copies of each ACR worksheet are accessible through CMS's Health Plan Management System (HPMS). CMS will provide separate detailed instructions pertaining to

- access to HPMS and related matters and
- submission of paper copies of the ACR and related back-up material.

The following sections explain how to fill out each individual worksheet in the ACR proposal. In addition to the instructions in this document, most electronic worksheets contain pop-up notes in many of the cells that provide limited on-line instructions for specific cells or groups of cells.

Please note that you must make certain entries described in subsequent chapters. When you submit (upload) your ACR to CMS via HPMS, the system will check for some of the required entries and will not permit an upload if any of that information is missing. To reduce the number of failed uploads, pre-upload validation software will be available for you to use before you submit your ACR. The validation software, which is separate from the ACR worksheets, will allow you to spot ACR errors such as missing required data. If you correct all the errors flagged by the validation software, your ACR workbook should be ready for a successful upload to HPMS. You must use the validation software for all of your HPMS uploads.

In addition, the electronic worksheets have built-in validation features that will prompt you to add or delete entries as appropriate. For example, cells highlighted in yellow signify a missing

entry in that cell or in a linked cell. On the other hand, cells highlighted or circled in red signify an unnecessary entry, perhaps one that belongs in another cell. In other examples, the worksheets will not allow negative entries or text entries where they are inappropriate.

The purpose of the validation features is to reduce common errors by users, thereby reducing the number and complexity of resubmissions of ACRs. Reduced complexity and fewer resubmissions reduce M+C organizations' workload and simplify the CMS review of ACRPs. CMS has noticed that, in the past, some organizations have defeated the ACR workbook validation features using copying commands or links to personal spreadsheets. Such techniques allow a user to enter values that the ACR worksheets would reject if the user typed the entries directly on to the worksheets. Please refrain from such copying and linking in order to facilitate the CMS review of ACRPs. M+COs will not be able to upload ACRs with values that do not meet the format rules built into the spreadsheets. Error messages in individual ACR worksheets will notify you if there are any entries that do not meet the format rules of the worksheet.

Employer-Sponsored and Union-Sponsored Enrollees in Service Area

When filing ACRs for M+C plans offered to individuals, an M+C organization should include on Worksheet B, in addition to the costs of individual plan members, the costs of employer-sponsored or union-sponsored members or both who reside in the service area of the individual plan. This does not include employer-sponsored or union-sponsored members who were members of a different plan in the base period. Employer-sponsored or union-sponsored members of an employer/union-only plan (see section 130 of this chapter) **that existed in the base period** are not to be included on Worksheet B in ACRs for M+C plans offered to individuals.

In addition, the Average Payment Rate (APR) for the M+C plan must also include projected employer-sponsored or union-sponsored enrollees or both who live in the plan service area and who are expected to enroll in the plan being priced in the ACR.

Chapter 2. Worksheet A—Cover Sheet

The Cover Sheet allows you to enter specific plan data that will be used in other worksheets. In addition, it summarizes the results of calculations from other worksheets. Finally, it contains a certification statement that M+CO officials must sign (on a paper version of the worksheet).

Part I A—Organization and Plan Data

The following paragraphs provide line-by-line instructions for Part I A of the worksheet.

General Information

Line 1—Name of M+C Plan. On line 1, enter the name of the M+C plan you are offering to Medicare enrollees. You must provide the name of the plan.

Line 2—Org. # (Organization Number). On line 2, enter the alphanumeric designation for the contract unique to this ACR proposal. The designation should begin with a capital P and include five Arabic numerals. Enter this number in the form of P#####. Please include leading zeros. For example, to enter P00122, include all five numbers. Obtain the Org. # number from your contract with CMS. You must enter it on line 2. Please do not enter the H-number (H#) here.

Line 3—H#. Enter the H-number for the plan on line 3. The designation begins with a capital H and includes four Arabic numerals. Enter this number in the form of H####. Please include all leading zeros. Obtain this number from your contract. You must enter the H# on line 3.

Line 4—Plan ID. The plan ID and the corresponding H#, forms a unique identifier for the plan being priced in an ACR. Plan IDs contain three Arabic numerals. You must enter a plan ID on Worksheet A. Enter the same plan ID on line 4 that was used for the corresponding PBP. Please remember to enter all leading zeros. For example, enter 001 for plan number one.

Line 5—Type of Plan. On line 5, enter the type of M+C plan, such as HMO, PPO, or PFFS. You must provide this information.

> ***REMINDER***—A separate ACR proposal must be submitted for each M+C plan, or segment.

Select one of the following codes from the drop-down menu on line 5.

Type of Plan:	Code:
♦ Coordinated care plans:	
• Health maintenance organizations	HMO

- Health maintenance organizations with a point-of-service (POS) option — HMOPOS
- Provider-sponsored organizations — PSO
- Preferred provider organizations — PPO
- Religious fraternal benefit plans — RFB

♦ M+C private fee-for-service plans — PFFS

♦ Non-M+C plan — non-M+C

Line 6—Enrollee Type. If an ACR prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, choose "Part A/B" from the drop-down menu for this cell. If an ACR prices an HMO or HMOPOS type of plan covering enrollees eligible only for Part B, choose "Part B-only" from the drop-down menu.

> ***REMINDER***—While nearly all M+C enrollees are eligible for both Part A and Part B of Medicare, some are eligible only for Part B benefits. CMS regards plans serving Part B-only enrollees as separate from plans serving Part A/B enrollees. Generally, ACRs that price plans serving Part B-only enrollees must be separate from ACRs that price plans serving Part A/B enrollees. However, if you offer your Part B-only members the same benefits as A/B members for the same price that A/B members are charged, then you are not required to submit a separate ACR for the Part B-only members. On the other hand, M+COs that enroll Medicare beneficiaries with Part B-only coverage in an employer-only or union only plan **must** prepare a Part B-only ACRP.

Line 7—ACR Contract Year. This cell is preloaded with the calendar year that contains the ending date for this ACR. The cell is locked. The period covered by an ACR must include at least 12 months and start on the first day of the calendar year (e.g., January 1, 2004) and end on the last day of the calendar year.

Line 8—Average Payment Rate ($PMPM). Line 8 displays the APR from Worksheet A1. The cell is linked to Worksheet A1 and therefore is locked. The APR is the amount an M+C organization estimates that CMS will pay (except for certain withheld amounts such as the information campaign user fee - if the plan chooses to exclude these amounts) in dollars and cents PMPM during the period covered by the ACR for each Medicare beneficiary electing the M+C plan you are pricing in the ACR.

Line 9—Contribution/Withdrawal-Stabilization Fund ($PMPM). Enter on line 9 the amount of contributions to or withdrawals from your stabilization fund in dollars and cents (two decimal places) per member, per month.

Contributions are the amount your M+C organization elects to deposit in a stabilization fund. Please enter contributions as a positive number. A contribution on line 9 of this worksheet cannot exceed 15 percent of the plan excess amount shown on line 9 of Worksheet E without prior CMS approval. CMS regulations also state that a contribution for the contract period cannot cause the total value of the plan's stabilization fund to exceed 25 percent of the excess amount applicable to the M+C plan for the contract period. If the contribution you enter does not meet the 15 percent test described above, the system will generate an error message on line 10 (Contributions to or Withdrawals from Stabilization Fund) of Worksheet E.

If your organization has previously established a balance in a stabilization fund and wants to withdraw an amount to stabilize benefits in the contract period of the ACR, enter a negative number on line 9 of this worksheet. You can request withdrawals from a stabilization fund if the plan meets the conditions in 42 CFR 422.312(c)(5).

The entry of a number other than zero in this cell will directly effect CMS's payment to you. In other words, CMS will change the monthly amount it will pay to the organization per Medicare enrollee by the amount on line 9 of this worksheet.

See section 80, Chapter 8 of the MMC manual for more information on stabilization funds.

Line 10—Number of Years to Hold Stabilization Fund. Enter the number of years, after the end of the period covered by the ACR, for which you want CMS to hold the amount you contribute to a stabilization fund. Amounts not withdrawn by the end of this period will be returned to Medicare. Please do not enter a value in this cell if your organization is not contributing to a stabilization fund during the contract year.

Line 11—Amount Withheld for Part B Premium Reduction ($PMPM). If your plan has a benefit providing for a reduction of Medicare Part B premiums for the plan enrollees, enter the amount in dollars and cents PMPM that you elect to have withheld from your monthly M+C payment for the contract period to fund the benefit.

BIPA permits Medicare+Choice organizations to offer reduced Medicare Part B premiums to their enrollees as an Additional Benefit. The mechanism to fund this reduction is for an M+C organization to elect a reduction in its Medicare+Choice payment of up to 125 percent of the annual Part B premium. CMS will apply 80 percent of this amount to reduce the Part B premium of plan enrollees; the remaining 20 percent will be savings to the M+C program.

The amount on line 11 of this worksheet also is limited by the amount of the adjusted excess on Worksheet E, Line 11. Therefore, do not enter an amount on line 11 of this worksheet exceeding the **smaller** of the adjusted excess on Worksheet E **or** 125 percent of the Original Medicare Part B premium. (As of May 2003, CMS projects that the Medicare Part B premium for 2004 will be $65.90 PMPM.).

For example, assume that the Part B premium is $65.90 PMPM and an M+C organization elects to have the full 125 percent of the Part B premium amount ($82.38 PMPM) withheld from its payment for each enrollee. Assume, too, that the adjusted excess amount on Worksheet E is $82.38 PMPM or more. Therefore, CMS would withhold the full $82.38 PMPM from its monthly payment to the M+C organization. In this example, CMS would apply 80 percent of

$82.38 ($65.90 PMPM) to reducing the Part B monthly premium that plan enrollees would have to pay directly to the Federal government.

As with other Additional Benefits, M+C organizations will have to apply reductions in the Part B premium uniformly to all plan enrollees. For more on this topic, see section 80 of Chapter 8 of the MMC manual.

Line 12—Medicare Deductibles and Coinsurance ($PMPM). CMS's Office of the Actuary computes the actuarial values of Original Medicare's deductible and coinsurance amounts in dollars and cents per member, per month. The amount on line 12 will be the correct amount for the enrollee type you choose for line 6 above. Line 12 also includes the actuarial value of Original Medicare's psychiatric co-payment amount as provided by CMS's Office of the Actuary.

You do not have to make an entry on this line. The cell is locked.

Enrollment Information

Line 13—Medicare Enrollment Capacity. Enter "unlimited" on line 13 if you have no Medicare enrollment capacity limit. Otherwise, enter Medicare enrollment capacity, which is the M+C organization's capacity allocated to Medicare beneficiaries during the contract period. Specifically, it is the total number of Medicare enrollees to which the M+C organization estimates it could reasonably provide the quantity and quality of benefits (with sufficient access) offered by the M+C plan during the period covered by the ACR. However, do **not** enter a value other than unlimited unless you also request approval through the Capacity Limit Module in HPMS. When entering a numerical value, please enter a whole number.

Line 14—Non-Medicare Enrollment Capacity. Enter the capacity allocated to non-Medicare enrollees during the contract period. This is the total number of non-Medicare enrollees to which the M+C organization estimates it could reasonably provide the quantity and quality of benefits (with sufficient access) offered by the same type of plan being priced in an ACR for the period covered by the ACR. Enter a value on this line unless your organization has no capacity limit. When entering a value, please enter a whole number. Enter "unlimited" on line 14 if you have no non-Medicare enrollment capacity limit.

Line 15—Projected Average Monthly Medicare Membership. This cell is linked to Part II of Worksheet A1. No entry is necessary. The cell is locked.

Line 16—Projected Avg. Monthly Non-Medicare Membership. Enter the average number of non-Medicare members (on a monthly basis for the entire contract period) expected to be enrolled in all benefit packages offered by your organization through the type of M+C plan being priced in this ACR. Please enter a whole number.

Line 17—Delegation of Authority to Submit Certain Changes. Complete a certification (at the bottom of Worksheet A) for each ACR as discussed in the section (below) on Certification Signatures. If an organization changes its ACR after the initial submission to CMS, the certification must be re-signed, re-dated, and submitted with the changed ACR unless you select

"yes" from the drop-down menu for line 17. In that case, the contact person named on line 8 of Part I B will be authorized to submit to CMS the types of changes described below without submitting a new, completed certification with the revised ACR:

- On Worksheet A—
  - Part I A, lines 13, 14, and 16
  - Part I B lines 7, 9, and 10.
- On Worksheets A1, B, B1, C, C1, D, and F, any unlocked cell, as long as the change does not affect Worksheet A of the most recent CMS-approved ACR for your plan.

Line 18—Actuarial Certification Provided. Federal law requires CMS actuaries to review ACRs. Many M+COs use actuaries to prepare ACRs, even though CMS does not require them to do so. If an actuary prepares your ACR, you can facilitate CMS review of your ACRP by submitting an actuarial certification for **each** ACRP. The certification should attest to the appropriateness of the actuarial methods and assumptions underlying the ACR. Your actuary or consulting actuary should sign the certification. While CMS recommends the following language for the certification, comparable language also would signify to CMS that the actuarial assumptions in question follow the appropriate Actuarial Standards of Practice.

I certify that, to the best of my knowledge and judgment, the data, actuarial assumptions, and actuarial methods underlying this Adjusted Community Rate Proposal conform to the appropriate Actuarial Standards of Practice, as promulgated by the Actuarial Standards Board, and that the results reasonably reflect the statutory purpose for which the estimates are prepared. Furthermore, I believe that the benefits provided by this plan are reasonable in relation to the total of the Medicare capitation payments and enrollee premiums.

M+COs are **not** required to submit an Actuarial Certification. However, if you do submit an actuarial certification, please choose "Yes" from the drop-down menu on line 18.

Part I B—Organization and Plan Data

The first five lines of Part I B provide 2-year trend calculations used in other ACR worksheets. For example, Worksheets D and Worksheet F both import trend data from this worksheet in order to calculate trended values for 2004. The trended values on Worksheet D and Worksheet F are the products of these trends and the base-period data on Worksheet B.

When completing this worksheet or Worksheet B, enter the data you have. Generally, you should not omit one type of requested data because you do not have another type of data. For example, if you have non-Medicare data for the base period and for the initial rate but don't have any Medicare enrollees in the base period, the ACR forms will compute a trend but will have no base-period data with which to compute trended values for 2004. In that case, you should not complete Worksheet B, but enter your 2004 data on Worksheet D or Worksheet F as appropriate. The following table tells you how to handle different situations of this general type.

Case	Problem			Solution			
	All Plans of Same Type of Plan in ACR		Plan in ACR	Worksheet A Part I B Non-Medicare Costs			
	Non-Medicare Enrollees in Base Period (2002)	Non-Medicare Enrollees in Contract Period (2004)	Medicare Enrollees in Base Period (2002)	Base Period (2002)	Initial Rate (2003)	Worksheet B (Medicare Costs)	Expected Variations (Worksheet D and Worksheet F)
a	b	c	d	e	f	g	H
1	Some	Some	Some	Fill In	Fill In	Fill In	Optional
2	None	None	None	Blank	Blank	Blank	Use for 2004 costs
3	Some	None	None	Fill In	Blank	Blank	Use for 2004 costs
4	Some	Some	None	Fill In	Fill In	Blank	Use for 2004 costs
5	None	Some	Some	Blank	Fill In	Fill In	Use for 2004 costs
6	None	None	Some	Blank	Blank	Fill In	Use for 2004 costs
7	Some	None	Some	Fill In	Blank	Fill In	Use for 2004 costs
8	None	Some	None	Blank	Fill In	Blank	Use for 2004 costs

The following paragraphs provide line-by-line instructions for Part I B of the worksheet

Non-Medicare Information: Column a—Base Period

Part I B, lines 1 through 5, of the worksheet will accept only positive entries ($PMPM). If you enter data on any one of lines 1, 2, or 4, you must enter data on all three lines.

Line 1—Collections from Enrollees. M+C organizations that had non-Medicare members in the base period must enter on line 1 their base-period collections from non-Medicare enrollees in dollars and cents per member, per month on an accrual basis. If your organization did not have non-Medicare members in the base period, leave line 1 (and lines 2 through 5) of column a blank.

Base-period collections are the average amount per member, per month collected (premiums and cost sharing) in the base period from all non-Medicare enrollees for all benefit packages offered by an M+C organization under the type of M+C plan being priced in an ACR. Report collections from enrollees under generally accepted accounting principles. The collections from enrollees should include all cost sharing charged to non-Medicare enrollees under the specific type of plan, regardless of who collected it. The collections from enrollees contain five components that represent

- direct medical care costs without reinsurance recoveries;
- reinsurance recoveries;
- administration costs;
- reinsurance premiums, and

- additional revenue received from enrollees in excess of the costs actually incurred in delivering the benefits contained in all of your non-Medicare benefit packages offered under this type of M+C plan.

Line 2—Direct Medical Care without Reinsurance Recoveries. Enter on line 2 direct medical care in dollars and cents per member, per month. Reduce direct medical costs by the amounts recovered from coordination of benefits efforts. In contrast, do *not* reduce direct medical care by the amount of any cost sharing paid by or on behalf of Medicare enrollees. Furthermore, do not reduce costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. (Enter reinsurance recoveries on line 3.)

Line 3—Reinsurance Recoveries. Enter the total amount of recoveries from reinsurance companies. Please enter a positive number, which the worksheet will convert to a negative value. Enter zero if you did not have a reinsurance policy in force for the base period.

Line 4—Administration. Enter on line 3 administration costs in dollars and cents per member, per month. Do not include reinsurance premiums, income taxes, or expenses related to investment activities in the cost of administration. (Reinsurance premiums should appear on line 5. The other items should not be included on this worksheet.) Include only those administration costs that bear a significant relationship to the type of plan you are pricing in the ACR.

Line 5—Reinsurance Premiums. Enter any reinsurance policy premiums you paid for the base period. Enter zero if you did not have a reinsurance policy in force during the base period.

Line 6—Additional Revenue. The worksheet calculates additional revenue in dollars and cents PMPM automatically. Line 6 contains the result of subtracting the sum of lines 2 through line 5 from line 1. The worksheet will permit negative values for additional revenue. The cell is locked.

Non-Medicare Information: Column b—Contract Period

Part I B, lines 1 through 5, of the worksheet will accept only positive entries ($PMPM). If you enter data on any one of lines 1, 2, or 4 you must enter data on all three lines.

Line 1—Initial Rate. M+C organizations that expect to have non-Medicare members in the contract year must enter the initial rate for that period on line 1 in dollars and cents per member, per month. Otherwise, leave line 1 (and lines 2 through 5) of column b blank.

The initial rate is an amount your organization calculates using a community rating system or a weighted average of premiums and cost sharing. It represents the average amount per member, per month in premiums and cost sharing expected to be collected (consistent with your business plan) from all non-Medicare enrollees for all benefit packages offered by an M+C organization under the same type of plan as the one priced in your ACR during the period covered by the ACRP. The initial rate should include all cost sharing to be charged to non-Medicare enrollees.

The initial rate contains five components that represent expected

- direct medical care costs without reinsurance recoveries;

- reinsurance recoveries;
- administration costs;
- reinsurance premiums, and
- additional revenue to be received from enrollees in excess of the costs actually incurred in delivering the benefits contained in all of your non-Medicare benefit packages offered under this type of M+C plan.

Refer to Chapter 8 of the MMC Manual for detailed instructions on computing the initial rate.

Line 2—Direct Medical Care without Reinsurance Recoveries. Enter on line 2 direct medical care in dollars and cents per member, per month. Reduce direct medical costs by the amounts recovered from coordination of benefits efforts. In contrast, do *not* reduce direct medical care by the amount of any cost sharing paid by or on behalf of Medicare enrollees. Furthermore, do not reduce costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. (Enter reinsurance recoveries on line 3.)

Line 3—Reinsurance Recoveries. Enter the total amount of recoveries you project for the contract year in the form of payments from reinsurance policies. Please enter a positive number, which the worksheet will convert to a negative value. Enter zero if you do not expect to have a reinsurance policy in force for the contract year.

Line 4—Administration. Enter on line 3 administration costs in dollars and cents per member, per month. Do not include reinsurance premium, income taxes, or expenses related to investment activities in the costs of administration. (Reinsurance premiums should appear on line 5. Do not include the other items on this worksheet.) Include only those administration costs that bear a significant relationship to the type of plan you are pricing in the ACR.

Line 5—Reinsurance Premiums. Enter any reinsurance policy premiums you project for the contract year. Enter zero if you do not expect to have a reinsurance policy in force for the contract year.

Line 6—Additional Revenue. The worksheet calculates additional revenue in dollars and cents PMPM automatically. The cell contains the result of subtracting the sum of lines 2 through line 5 from line 1. The worksheet will permit negative values for additional revenue. The cell is locked.

Non-Medicare Information: Column c—Two-Year Trend

Line 1 through Line 5—Trend Calculation. The worksheet automatically calculates a trend value on lines 1 through 5 of column c. The trend is the 2-year change between the base period and the contract year. In other words, the trend values are not annualized. The ACR forms apply trend values to relevant base-year costs using formulas in Worksheet D and Worksheet F to calculate trended values for certain individual health care components and other values.

If there are any blank entries on lines 1, 2, or 4 of column a or column b, “No trend” will appear in lines 1 through 5 of column c. In that case, the worksheet does not compute any trended

values. Instead, you must enter your best estimates of the costs of individual health care components in the appropriate expected variation cells of Worksheet D and Worksheet F.

The worksheet does not calculate a trend for line 6 (Additional Revenue). As described above, additional revenues are not projected separately, as are the costs of health care components and other values. Instead, the ACR forms calculate contract-year values for additional revenues as residuals on Worksheet D. (The residual amount is the trended value on the total lines of Worksheet D less the trended values of health care components and other values in the same column.)

The cells for lines 1 through 6 in column c are locked.

NOTE—If the loss ratio (direct medical costs divided by total revenue requirements) decreases between the base period and the contract year, CMS may ask you to document the reasons for the decrease.

Organization Name and Plan Contact

Lines 7 through 10 in Part I B of the worksheet will accept text entries.

Line 7—Name of M+C Organization. Enter the name of the M+C organization submitting the plan priced in the ACR.

Line 8—Plan Contact Person's Name and Position. Enter the name and position title of the person whom CMS should contact for answers to questions about your ACR.

Line 9—Plan Contact Person's Telephone Number and Area Code. Please enter the telephone number (with the area code) of the person listed on line 8. Enter all 10 digits consecutively without parentheses or dashes.

Line 10—Plan Contact Person's E-mail Address. Please enter the e-mail address of the person listed on line 8. If the person has no e-mail service, enter "None."

Part II—Summary of M+C Enrollee Charges from Worksheet C

Part II is a summary of certain charges affecting M+C enrollees of the plan. The worksheet imports the data from Worksheet C. No entries are required. The cells are locked.

Part III—Medicare Part B Premium

The worksheet has a preloaded value of $65.90 PMPM on line 1. People who are eligible for benefits from Part B of Medicare must pay a premium to the Federal government even though they join the M+C program. When CMS published these instructions, its estimate of that premium was $65.90 PMPM.

If your M+C plan is going to offer a benefit in 2004 that will pay all or part of your plan enrollees' Medicare Part B premium, please check with CMS to make sure it has not announced a revised estimate of the Part B premium for 2004 since it published these instructions. If CMS has announced a revised estimate of the Part B premium, enter the PMPM amount of the new premium on line 1.

Entering the new premium automatically will adjust limits built into the worksheets that will keep you from entering too large a number on Worksheet A, Part IA, line 11 (see the discussion of line 11). Line 11 represents the amount to fund the benefit that pays Part B premiums and that CMS will withhold from its monthly payment to your organization.

If your plan is not going to offer such a benefit in 2004, ignore Part III of Worksheet A.

Certification Signatures

Both the chief executive officer and the chief financial officer **must** sign and date the certification at the bottom of Worksheet A.

In general, certification signatures are required for the initial ACR and any modified ACRs submitted after the initial one. However, you may omit certification signatures when you modify ACRs under certain circumstances. See the instructions for line 17 of Part I A.

Please type the name of each official in the box above the corresponding position title.

Chapter 3. Worksheet A1—Service Area and Estimate of Average Payment Rate

Worksheet A1 calculates the APR for the plan priced in this ACR. The APR from this worksheet also appears on Worksheet A, Worksheet E, and Worksheet G. Please complete Worksheet A1 for all plan types.

Note that the APR for a plan should reflect the revenue you expect to receive from CMS based on the membership you project for that plan.

The worksheet automatically copies the **Name of M+C Plan, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Alternative Methodology

You are not required to use the full methodology of Worksheet A1. An M+CO that wishes to use a different method for computing its estimated payment by county can enter zeros in columns d, g, and j of Part I of this worksheet. The M+CO then can enter its computed average payment amount for all projected enrollees in column p (Plan Adjustment). The only other required entries are membership data in column m (non-ESRD) and column n (ESRD). Please explain in detail any entries in column p in your back-up materials submitted to CMS with your ACR. **Show all calculations and assumptions.**

If the plan you are pricing did not operate in 2003, you must use an alternative methodology. The full method on Worksheet A1 works only for pricing ACRs that are renewing an M+C plan that operated in CY 2003.

Worksheet A1 Full Methodology

The worksheet calculates a plan's CY 2004 APR by first calculating the total CMS payment for each county in the plan service area. Next, the worksheet calculates the plan APR PMPM as an average of total payments for all counties, weighted by your projection of plan membership.

All data entry occurs in Part I (County Specific Rate Computation) of the form. The final computation of the APR (in Part II-Average Payment Rate) is a calculated field that does not accept data entry.

If you project your plan will have no members in 2004, the worksheet will **not** compute an APR.

Part I—Plan Service Area and Calculation of APR by County

The following paragraphs describe each column of Part I. The form has 8 fields in Part I that you must fill in for each county in the service area (even if that county has no projected membership). Optional data entry is permitted in column t (2004 Plan Adjustment). The remaining columns are locked.

Columns Requiring Data Entry

1. Column a—State-County Codes

Before making entries in column a, please read the following instructions:

a. Use code 99999 to create a line for data concerning out-of-area enrollees. When you use code 99999, the term "Unassigned" will appear in column b (County Name).

b. Enter the Social Security Administration (SSA) State-county codes that define the new M+C service area for the M+C plan you are pricing in the ACR.

c. Enter each code in the form of ##### (the two-digit State code followed by the three-digit county code). Please enter any leading zeros (e.g., the zero in code 01234) so that you have a correct five-digit code. There can be up to 50 State-county codes on the spreadsheet. If your plan has more than 50 counties, contact CMS for a customized Worksheet A1.

d. If you enter a non-valid State-county code (e.g., too few digits, too many digits, a code not used by SSA), "N/A" will appear on the same line in several columns of the worksheet. Moreover, for certain errors, a dialogue box with suggestions for corrections will appear. In that case, you will have to click on "retry" or "cancel" to continue making entries.

e. If the plan service area has more than one county, do not leave any blank cells between the first and last State-county codes in column a. If you try to type a State-county code in a cell below a blank cell, an error message will appear. To eliminate the error message, click on "Retry" or "Cancel" in the dialogue box of the error message. Then, enter a valid State-county code in the cell just below the last one that contains a state-county code. If you erase a State-county code from the worksheet, thereby leaving a blank cell between other State-county codes, the worksheet will not compute the APR until you correct your errors.

f. If you enter the same State-county code more than once, the other duplicated cells in column a will turn red to prompt you to delete the duplicate entries.

g. Please contact CMS if you are unable to enter a valid State-county code in column a.

2. Column d—CY 2003 Actual Aged Demographic Rate (PMPM). The actual aged demographic rate is equal to what CMS paid you PMPM in 2003 for the aged, non-ESRD members in the plan you are pricing. The amount is based on the demographic metrics (e.g., age, sex, hospice, working-aged, institutional, Medicaid) that applied to the plan enrollment in 2003. You can get this value from your own data system. On the other hand, you can derive the value from the CMS Monthly Membership Report or you can use the CMS-provided MMR Tool described at the end of this chapter.

If the plan or county you are pricing for 2004 did not operate in 2003, enter zeros in column d. You will have to enter your estimate of your average payment rate in column t.

Please enter a value between 0 and $3000 PMPM in column d for each county in which you had aged, non-ESRD members in 2003 in the plan you are pricing.

If you project no aged, non-ESRD members for a county, enter zero in this column for that county.

3. Column g—CY 2003 Actual Disabled Demographic Rate. The actual disabled demographic rate is equal to what CMS paid you PMPM in 2003 for the disabled, non-ESRD members in the plan you are pricing. The amount is based on the demographic metrics (e.g., age, sex, hospice, institutional, Medicaid) that applied to the plan enrollment in 2003. You can get this value from your own data system. On the other hand, you can derive the value from the CMS Monthly Membership Report or you can use the CMS-provided MMR Tool described at the end of this chapter.

If the plan or county you are pricing for 2004 did not operate in 2003, enter zeros in column g. You will have to enter your estimate of your average payment rate in column t.

Please enter a value between 0 and $3000 PMPM in column g for each county in which you had disabled, non-ESRD members in 2003 in the plan you are pricing.

If you project no disabled, non-ESRD members for a county, enter zero in this column for that county.

4. Column j—Average Risk Factor. Please enter an average risk factor for each county. CMS will give many M+COs an overall risk factor for their contract (H-number). The average risk factor is a quantification of a set of underwriting factors (e.g., diagnoses from hospital stays and ambulatory settings, age, sex). You can use the CMS risk factor for all counties in a plan under the H-number or for all counties in all plans under the H-number. You can adjust this factor to account for expected variance between counties and plans, or you can use your own risk factor. An aggregate risk factor, based on the values you use, will appear in Part III (Plan Risk Score) of the worksheet.

If the plan or county you are pricing for 2004 did not operate in 2003, enter zeros in column j. You will have to enter your estimate of your average payment rate in column t.

CMS did not send an overall risk factor for 2004 to all M+COs. M+COs that did not receive an impact estimate and average risk score can use a risk score that they develop by running their

data through the CMS-Hierarchical Condition Category (CMS-HCC) model, or they may use the county average risk score available at http://www.cms.hhs.gov/healthplans/rates/default.asp. The county average rates are located there in column e (Medicare benes) of a document called "risk2004.csv."

The values in column j must be between 0 and 3.5.

M+COs should indicate, in their back-up materials for each ACR, whether they used the CMS-provided risk factor, the CMS-derived risk score using the CMS-HCC model, or the M+CO's own average risk factors. **M+COs that use their own average risk factors must include an explanation of the methodology in the back-up material submitted with their ACR. The back-up material must show all calculations and assumptions**.

If you project no non-ESRD members for a county, enter zero in this column for that county.

5. Column m—CY 2003 Actual ESRD Rate. The actual ESRD rate is equal to what CMS paid you PMPM in 2003 for the ESRD members in the plan you are pricing. You can get this value from your own data system. On the other hand, you can derive the value from the CMS Monthly Membership Report.

If you project no ESRD members for a county, enter zero in this column for that county.

6. Column p—CY 2004 Average Monthly Membership (Aged). Please enter the expected average monthly aged, non-ESRD membership in CY 2004 for each county in the plan service area. You can enter any positive whole number or zero in column m. If a county has no projected membership, enter zero.

Members can be enrolled in only one M+C plan at a time. Therefore, if the organization has multiple plans in a county, ensure that membership estimates for all plans in a given county are mutually exclusive. If you enter a negative value, an error message will prompt you to correct it.

7. Column q—CY 2004 Average Monthly Membership (Disabled). Please enter the expected average monthly disabled, non-ESRD membership in CY 2004 for each county in the plan service area. You can enter any positive whole number or zero in column m. If a county has no projected membership, enter zero.

Members can be enrolled in only one M+C plan at a time. Therefore, if the organization has multiple plans in a county, ensure that membership estimates for all plans in a given county are mutually exclusive. If you enter a negative value, an error message will prompt you to correct it.

8. Column r—Average Monthly Membership (ESRD). Please enter the expected average monthly ESRD membership in CY 2004 for each county in the plan's service area. You can enter any positive whole number or zero in column n. If a county has no projected membership, enter zero. Members can be enrolled in only one M+C plan at a time. Therefore, if the organization has multiple plans in a county, ensure that membership estimates for all plans in a given county are mutually exclusive. If you enter a negative value, an error message will prompt you to correct it.

Column t—Plan Adjustment.

Please enter any adjustment you wish to make to the composite rate in column s.

You can enter both positive and negative numeric values in column t. However, the number you enter in this column cannot make the payment (the value in column u) negative.

If you entered zero for the demographic rate and zero for the risk factor, you should enter your computed payment amount here as the adjustment.

In addition, include in this column adjustments to add back any items that CMS withheld from your actual CY 2003 payments. Examples of such items are the Information Campaign User Fee, your deposits into a stabilization fund, and any amounts withheld to reduce enrollees' Part B premiums. Furthermore, make adjustments in column p to subtract any payments from CMS that were included in the data you reported for 2003 and that reflect a withdrawal from amounts in a stabilization fund. Please refer to section 110 of Chapter 8 of the MMC for a discussion of how to handle user fees in the APR and ACR calculations. As indicated in that section, you have the option to include or exclude user fees from the APR and ACR calculations as long as you are consistent in both calculations.

Examples of other circumstances for which you can make adjustments in this column are:

- Expected changes in demographics
- Expected changes in health status of enrollees
- One-time adjustments in 2003 for circumstances in earlier years
- Part-B only members in a plan for Part A/B enrollees (If you fail to adjust for a significant number of Part B-only enrollees, the average risk rate will be overstated.)

Please explain in detail any entries in column p in your back-up materials submitted to CMS with your ACR. **Show all calculations and assumptions.**

Other (Locked) Columns in Part I

The cells in the following columns are locked; users need make no entries.

Column b—County Name. The worksheet will enter the county name that corresponds to the State-county code on the same line in column a. Contact CMS if the county name does not appear. The county name may help users to spot errors in their State-county code entries.

"Unassigned" will appear in this column if you use code 99999.

Column c—State Name. The worksheet will enter the postal abbreviation for the State that corresponds to the State-county code that you enter on the same line in column a.

Column e—Percent Rate Increase (Aged). This column displays the percentage increase in the CMS M+C aged rate from 2003 to 2004. The worksheet computes the change in aged rates from the CMS M+C rate books for 2003 and 2004.

Column f—CY 2004 Average Aged Demographic Rate ($PMPM). This column displays the product of column d multiplied by one plus the value in column e [$col.f = col.d \times (1 + col.e)$].

Column h—Percent Rate Increase (Disabled). This column displays the percentage increase in the CMS M+C disabled rate from 2003 to 2004. The worksheet computes the change in aged rates from the CMS M+C rate books for 2003 and 2004.

Column i—CY 2004 Average Disabled Demographic Rate ($PMPM). This column displays the product of column g multiplied by one plus the value in column h [$col.i = col.g \times (1 + col.h)$].

Column k—CY 2004 County Risk Rate ($PMPM). This column displays the risk rate for each county in column a. The values are the product of the aged rates times the corresponding rescaling factors from the CMS M+C rate book for 2004.

Column l—CY 2004 Average Risk Rate ($PMPM). This column displays the product of columns j and k.

Column n— Percent Rate Increase (ESRD). This column computes the percentage increase in the ESRD rate from 2003 to 2004. The value is based on the ESRD rates in the CMS M+C rate books for 2003 and 2004.

Column o—CY 2004 Average ESRD Rate ($PMPM). This column displays the product of column m multiplied by one plus the value in column n [$col.o = col.m \times (1 + col.n)$].

Column s—Composite Rate ($PMPM). This column displays a weighted average payment rate that includes the blended aged and disabled non-ESRD rate (70 percent demographic/30 percent risk adjusted) and the ESRD rate. If you have no adjustments in column t, column s displays the average payment rate for each county in the plan.

Column u—Estimated County APR ($PMPM). This column displays the sum of column s and column t.

The average payment rate for the plan will appear in Part II. If the worksheet is incomplete or if you project no members, the word "Error" will appear on the last line.

Part II—Average Payment Rate (APR)

Part II displays the CY 2004 plan APR and other values automatically calculated from the data in Part I. All the cells in Part II are locked; users need not make any entries.

The values in Part II are defined as follows:

The **Number of Counties in this Plan** is the sum of the non-blank cells in Part I, column a.

The **CY 2004 Total Estimated Membership** is the sum of the entries in columns p, q, and r of Part I.

The **CY 2004 Total Estimated Monthly Payment ($PMPM)** is the sum of the estimated total payment values by county. The cell sums the individual products of column u times the sum of columns p, q, and r for each line in Part I.

The **CY 2004 Estimated APR ($PMPM)** is the average of county APRs in Part I, column u, weighted by county membership. If the worksheet is incomplete or if you project no members in the plan for 2004, the word "Error" will appear on this line.

Part III—Plan Risk Score

Part III displays an aggregate risk factor based on the values you use in Part I.

Instructions for Using Optional MMR Tool

As indicated in the discussion of Part I, column d, CMS is providing an MMR tool to help you estimate your annual demographic rate. You can use this tool if you wish, but CMS does not require you to do so.

General Information

The MMR Tool is an *Excel*-based program that can read multiple files containing Monthly Membership Reports (MMRs) to produce summary payment information over one or multiple months. You can summarize by county and you can select a specific plan ID.

To use the tool you need to:

- have Microsoft *Excel* 2000 on your personal computer.
- download the MMR Tool from http//:www.cms.hhs.gov.
- have macros enabled within *Excel*. To do this, open *Excel* and then select Tools, Macros, and Security. Set the security option to either low or medium.
- obtain electronic copies (text format) of the MMRs you wish to use and store them on a disk drive accessible from your personal computer.

Detailed Instructions

Start *Excel* and open the program file called “MMRCalcs12.xls.” If your security level is medium, select "Enable Macros" when the tool prompts you.

If the Main Control Screen does not appear, select it by clicking its tab at the bottom of the *Excel* worksheet. Click the "Instruction" button on the Main Control screen and follow the steps shown in the box that appears. We also show those instructions here:

a. Click the "MMR Files" tab (at the bottom of the *Excel* spreadsheet) and specify the MMR report files (from previous year) that you want to include.

b. Return to the Main Control Screen and specify your input parameters (i.e., number of payment months, plan ID, and summary option).

- Payment months are the months of data all specified MMR files contain.

- Plan ID is the identification number of the M+C plan for which you want payment information. (You can select all plans or one specific plan contained in the MMR files you specified. However, because CMS adjustment entries in MMR files are not plan specific, **only** the ALL option will include them. See the box below regarding CMS adjustments in the MMR data files)

- Summary option lets you specify how you want data summarized. The options are self-explanatory.

c. If you selected Summary Option 2, select the "Service Area" tab (at the bottom of the *Excel* spreadsheet) to specify the service area for your analysis.

d. Click the "Perform Rate Analysis" button.

e. The tool will display results by county and for the entire Plan ID specified.

f. If cell B8 displays a message starting with "Analysis incomplete," the program encountered a problem in finding one or more of your MMR files. You should re-specify the files and run the MMR Tool again.

g. To clear the results, select the "Clear Results" button.

The results of performing the rate analysis will show several columns of data with summary payment information. For each state and county in the summary, the tool will display average monthly membership data broken down by aged and disabled non-ESRD membership and ESRD membership. It will also show various rate components including the average ESRD rate you were paid, the average aged and disabled non-ESRD demographic and risk rates in your payment report, the average blended rate you were paid for aged and disabled non-ESRD members (90% of the demographic rate and 10% of the risk-adjusted rate for 2003).

The tool also will show a composite average rate per member for each county. You can scroll through the various counties in the summary. Note that while the tool displays the average membership as a whole number, the number in the cell could contain a decimal due to averaging across months. The tool will show summary information for all the counties in the plan you selected.

The information you need from the MMR Tool for entry in to Worksheet A1 is the non-ESRD demographic payment rates for aged and disabled enrollees and the average ESRD payment rate, all for each county in your plan service area. Note that if you used Option 2 (one record for each county in the service area), you will also get a record for all members not in the service area. You can enter information for these members as a separate county using State-county code "99999". Finally, you can use the ESRD, disabled, and aged membership numbers from the tool in worksheet A1 if they reflect the membership you project for the plan in CY 2004.

CMS Adjustments in MMR Data Files

Current Monthly Membership Reports do **not** show M+C plan IDs for adjustment transactions. Therefore, if you run the MMR tool for a specific plan ID, the results will **not** reflect any adjustment data. On the other hand, if you run it for **all** plans under a given H-number, the results **will** include adjustments. To help in understanding the affect of the adjustments, the MMR tool contains a box in the upper right hand corner showing the effect of adjustments on the aggregate results. Specifically, the box shows the effect of the adjustments on the results (i.e., values **with** adjustments included minus equivalent values **without** adjustments). The MMR tool breaks down the data by type of member (ESRD, Aged, or Disabled) and type of payment (demographic or risk in the case of aged and disabled). You may wish to adjust individual plan PMPM rates (ESRD, aged demographic, disabled demographic) using these adjustment values **before** entry into Worksheet A1.

Chapter 4. Worksheet B—Base-Period Costs and Enrollment

Worksheet B contains the base-period data that the ACR forms use for calculating the contract-year costs of individual health care components. Medicare costs for the base period should reflect the experience for the same plan you are pricing in the ACR. Worksheet D and Worksheet F import Worksheet B data for direct medical costs, administration, and additional revenues to compute trended values for 2004. When Worksheet A contains 2-year trends based on costs for the M+C organization's non-Medicare enrollees, Worksheet D and Worksheet F both apply the trends to base-period data for trended value computations.

This chapter contains both general information about Worksheet B and specific line-by-line instructions for completing the worksheet. Some M+C organizations may not have base-period costs for the plan they are pricing in an ACR. The chapter tells you how to handle that situation.

General Information

This section covers information and concepts that apply broadly to the entries required for Worksheet B.

Base Period Defined

The base period is the most recently ended calendar year before the ACR is submitted. For example, the base period is calendar year 2002 for ACR proposals submitted in calendar year 2003 for contract year 2004. If your plan had Medicare enrollees in the base period, record on this worksheet Medicare revenue received and costs actually incurred during the base period.

> ***EXCEPTION***—As explained below in instructions for lines 20 and 21, the coordination of benefits (COB) amount you report is not necessarily actual COB collections.

Total Costs Reflected

Worksheet B reports information reflecting the total costs for Medicare enrollees for the base period. In addition, Worksheet B costs should include all cost sharing (i.e., co-payments, coinsurance, and deductibles) charged to plan enrollees. In other words, do not reduce the costs on Worksheet B by the amount of cost sharing charged to plan enrollees (regardless of who collects the cost sharing). However, you would remove the value of benefits that are a result of private negotiations in the context of the M+C program (e.g., with employer or union groups) and certain Medicaid benefits (see 42 CFR 422.106 for further explanation).

Receipts from Reinsurance and COB

Reflect receipts from reinsurance and amounts that could have been collected for COB on Worksheet B.

Reduce total costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. Do not assign the amounts from reinsurance recoveries as an offset to the costs for related health care components. Rather, show reinsurance recoveries and premiums as a total on lines 23 and 26.

Reduce total direct medical costs by the amounts that could have been collected for COB. Show separately on lines 20 and 21 any amounts that could have been collected for COB related to medical care provided to Medicare enrollees, if you had made a "good faith" effort to recover these amounts. (See section 140 of Chapter 8 of the Medicare Managed Care Manual.)

Accrual Accounting and Related Considerations

The accounting system used to report base-period entries should be accrual-based (an exception to the accrual method of accounting may be approved for certain governmental organizations).

Worksheet B should include only entries properly accrued to the base period and those entries should track to financial statements that comply with GAAP for that period.

The method used in your accounting system to determine the cost PMPM for Medicare enrollees must be the same method used to determine the PMPM for non-Medicare enrollees. In addition, the costs allocated to each category must represent a fair distribution of costs. Include on Worksheet B only those administration costs that bear a significant relationship to the M+C plan elected by Medicare enrollees.

The same accounting methods should be used for all columns of the worksheet.

Plans Without Trends (Plans Without Non-Medicare Enrollees)

An M+C organization without non-Medicare enrollees in the base period, the contract period, or both periods can offer an M+C plan. In such cases, M+C organizations will not have all the data needed to complete Worksheet A, Part I B, lines 1, 2, and 4. Therefore, Worksheet A cannot compute a 2-year trend and Worksheets D and F cannot compute trended values for 2004. Nevertheless, the M+C organization still should report base-period costs on Worksheet B if the plan being priced had Medicare enrollees in the base period. The M+C organization then would use budget data to compute projected values for 2004 and record them in the expected variation cells on Worksheet D and Worksheet F.

Plans with Atypical Base-Year Costs

An M+C plan could have base-period M+C costs that the sponsoring organization considers unrepresentative and therefore views the data as unsuitable for making cost projections for 2004.

Your organization could take that position for many reasons, such as when a plan operated for only a short time in the base period or had relatively few enrollees then.

Nevertheless, you should report your actual costs even though you may consider your 2002 experience to lack credibility. Enter your actual costs on Worksheet B and make necessary adjustments to any trended values on Worksheet D, Worksheet F, or both. Enter such adjustments in the expected variation cells provided on Worksheet D and Worksheet F.

Plans Without Base-Period Data

In 2004, an M+C organization might offer a plan that did not operate in the base period. Examples of this include plans starting in 2003 or 2004.

If your plan had no Medicare enrollees in the base period, leave Worksheet B blank. Record your costs for CY 2004 as expected variations on Worksheet D, Worksheet F, or both. Use your budget data to compute projected values for 2004.

For more on this issue, refer to the table at the beginning of the discussion of Worksheet A, Part I B in Chapter 4 (below).

Effect of Service Area Changes on Worksheet B Data

An M+C organization might prepare an ACR to renew an existing plan that will have a different service area than the plan had in the base period. Nevertheless, Worksheet B data will not be affected by the service area change. In other words, the costs on Worksheet B should reflect the plan service area in the base period and *not necessarily* the contract-year service area.

> ***REMINDER—***If the base-period service area of your plan is different from the contract-year service area, enter adjustments (expected variations) on Worksheets D and F as necessary to make the estimates on those worksheets consistent with the contract-year service area.

No Grouping of Statutory Benefit Categories

To make the contract year ACR as accurate as possible, display Medicare enrollee revenue and costs for the base period in the column that reflects the statutory classification (i.e., Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits) in the PBP for the contract-year plan. (For more on the previous point, see the instructions for lines 1 through 25.) This information will be used as the basis for calculating the amount CMS will allow an M+C organization to charge Medicare enrollees for an M+C plan.

Grouping of Health Care Components

You do not need to use all health care components (lines) for your ACR. You must use the categories of Direct Medical Care, Administration, and Additional Revenue (and POS, if the plan

being priced is an HMOPOS). The other categories you use will depend on your accounting system. See the 2004 Call Letter and the "2004 ACR Transmittal Instructions" for specific requirements. Your accounting system must be able to produce cost figures consistent with the ACR format, as completed, in a manner that may be audited. Include with your ACR a document showing the benefits that have been grouped and the health care components to which they were assigned.

Please make every effort to make the content of each health care component on Worksheet B consistent with the classification used in the PBP.

> ***EXCEPTION*—**Do not group the costs of individual Optional Supplemental Benefits on Worksheet B. Displaying them separately on Worksheet B will allow the related trended values to be shown separately on Worksheet F. That in turn will allow the ACR forms to price the Optional Supplemental Benefits separately on Worksheet F by health care component, as required by CMS regulations.

Format of Base-Period Entries

Worksheet B will allow users to make entries using up to two decimal places except for line 30, which requires whole numbers, and the cells for the begin and end dates of the base period, which require a date format. The worksheet will not allow text entries (e.g., "N/A"), nor will it allow negative entries except on COB and additional revenue lines. Error messages will prompt you to correct entries with the wrong format.

Line-by-Line Instructions

The following paragraphs provide line-by-line instructions for completing Worksheet B.

Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type**, and **Plan ID** from Worksheet A. If "select choice" or "enter data" appears in any of these cells, make the correct entry on the corresponding cell of Worksheet A.

Begin date. Enter the beginning date of the base period in date format (mm/dd/yyyy).

End date. Enter the end date of the base period in date format (mm/dd/yyyy).

Line 1 through Line 30

When an M+C organization offers a collection of benefits with a common theme, such as a continuation package or a visitor program, the cost of the benefits must be broken out and shown under the correct health care component (except where CMS has allowed grouping, as discussed

above). In any event, show the cost for each health care component under the correct statutory category or categories.

> ***EXCEPTION***—If an M+C organization includes a POS benefit in a plan, price the benefit separately and include all of the direct medical costs on line 19 (POS).

Line 1 through Line 19.

Column a: On line 1 through line 19 of column a, the worksheet will enter the sum of the amounts on corresponding lines in columns b, c, and d. The cells in column a are locked; users need make no entries.

Columns b, c, d, and e. In columns b, c, d, and e**,** record the correct cost data for each type of benefit, based on whether the benefit is Medicare-Covered, an Additional Benefit, a Mandatory Supplemental Benefit, or an Optional Supplemental Benefit. (Note that the PMPM cost data for Optional Supplemental Benefits should be based on the member that selected the benefits, not on total plan members or total members that selected any optional supplemental benefit.) For line 1 through line 18 of column b and line 1 through line 19 of columns c, d, and e, if the benefit will be offered in the contract year, enter the base-period data in the column under which the benefit would be classified (Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits) for the contract-year plan. If the benefit will not be offered in the contract year, enter the base-period data in the column under which the benefit was classified for the base period plan, and make a corresponding adjustment in Worksheet D. The following table may help to illustrate the application of this procedure.

Case	Statutory Benefit Category in PBP for Base Period (2002)	Statutory Benefit Category in PBP for Contract Year (2004)	Statutory Benefit Category for CY 2004 ACR Costs on Worksheet B	Adjustment on CY 2004 ACR Worksheet D
Benefit to be in new statutory benefit category in contract year	Optional Supplemental Benefits	Mandatory Supplemental Benefits	Mandatory Supplemental Benefits	None
Benefit to be in same statutory benefit category in base period and contract years	Optional Supplemental Benefits	Optional Supplemental Benefits	Optional Supplemental Benefits	None
Base-period benefit to be dropped in contract year	Optional Supplemental Benefits	None—not offered in CY 2004	Optional Supplemental Benefits	Enter an amount equal to trended value but with a negative sign
New benefit for contract year	None—the benefit was not offered in the base period.	Optional Supplemental Benefits	Do not show costs on Worksheet B, because the benefit was not offered in the base period.	Provide your best estimate of the benefit cost. Show the cost as an Optional Supplemental Benefit.

NOTE—When entering the adjustments described in the above table on Worksheet D, be sure to enter on lines 25 and 27 of that worksheet any related offsets to the costs of administration and to additional revenue.

If an Additional Benefit or a supplemental benefit is an extension of a Medicare-Covered Benefit (for example, the benefit allows more hospital days than are covered under Medicare), record the Medicare-covered amount under column b. Record the difference between the total benefit and the Medicare-covered amount, as appropriate, under Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits.

42 CFR 422.105 states that POS benefits can be offered as an Additional Benefit, a Mandatory Supplemental Benefit, or an Optional Supplemental Benefit. Accordingly, POS benefits cannot be offered as a Medicare-Covered Benefit. As a result, line 19 (POS) is blocked out under the Medicare-covered category (column b). Line 19 relates only to POS benefits. Aggregate costs of POS benefits on line 19 under the appropriate columns. Furthermore, you should obtain CMS approval for POS benefits you wish to offer before you submit an ACR with those benefits.

Line 20 and Line 21.

Column a. The value on line 20 of column a is the same as the value on line 20 of column b. On line 21 of column a, the worksheet will enter the sum of the amounts on corresponding lines in columns b, c, and d. The cells are in column a are locked; users need make no entries.

Columns b, c and d. Please note that column b, line 20, and columns b through d, line 21 should reflect the coordination of benefits (COB) amount that the M+C organization could have collected if it had made a "good faith" effort to recover (regardless of the actual amount collected) when Medicare was the secondary payer for a given health care benefit. The COB amount to which M+C organizations are entitled in such instances is based on actual liabilities of other insurance coverage that Medicare enrollees have. Enter COB-Other amounts on line 21 in the same column (column b, c, or d) that you used to classify the costs of the base-period benefits to which the COB payments are related.

Column e. You cannot enter COB–Other in column e on line 21. Instead, you allocate COB–Other for Optional Supplemental Benefits to the individual entries in column e, lines 1 through 19. Please show in your ACR back-up material the amount of COB-other that you allocated to **each** Optional Supplemental Benefit.

Lines 22 through 28

Column a: On lines 22 through 28 of column a, the worksheet will enter the sum of the amounts on corresponding lines in columns b, c, and d. The cells in column a are locked; users need make no entries.

Columns b, c, d, and e:

Line 22—Subtotal displays the subtotal of the preceding lines in each column of the worksheet.

Line 23—Reinsurance Recoveries. Enter the sum of any reinsurance recoveries the plan has received, or is expected to receive, on claims incurred during the base period under each column, except column e. Do not reduce the amounts showing on the individual lines 1-19 by the amount of reinsurance recoveries. Instead, show all reinsurance recoveries on this line. However, you cannot enter amounts for reinsurance recoveries in column e on line 23. Instead, allocate the amount of any reinsurance recoveries for Optional Supplemental Benefits to the individual entries in column e, lines 1 through 19. Please show in your ACR back-up material the amount of any reinsurance recoveries that you allocated to **each** Optional Supplemental Benefit.

Line 24—Subtotal - Direct Medical Care sums the values on lines 22 and 23.

Line 25—Administration. Enter the costs of administration actually incurred in accord with GAAP. Show base-period Medicare costs for administration in the same column (column b, c, d or e,) that you use to classify the costs of the base-period benefits to which those entries are related. However, you cannot enter amounts for administration in column e on line 25. Instead, allocate the amount of administration costs for Optional Supplemental Benefits to the individual entries in column e, lines 1 through 19. Please show in your ACR back-up material the amount of administration costs that you allocated to **each** Optional Supplemental Benefit.

Line 26—Reinsurance Premium. Enter base-period reinsurance premiums in the same column (column b, c, d, or e) that you use to classify the costs of the base-period benefits to which those entries are related. However, you cannot enter amounts for reinsurance premiums in column e on line 26. Instead, allocate the amount of any reinsurance premiums for Optional Supplemental Benefits to the individual entries in column e, lines 1 through 19. Please show in your ACR

back-up material the amount of any reinsurance premium that you allocated to **each** Optional Supplemental Benefit.

Line 27—Additional Revenue. Enter additional revenue collected and properly accrued in accord with GAAP. Show base-period Medicare costs for additional revenue in the same column (column b, c, d, or e) that you use to classify the costs of the base-period benefits to which those entries are related. However, you cannot enter amounts for additional revenue in column e on line 27. Instead, allocate the amount of additional revenue for Optional Supplemental Benefits to the individual entries in column e, lines 1 through 19. Please show in your ACR back-up material the amount of additional revenue that you allocated to **each** Optional Supplemental Benefit.

Line 28. Total. This line shows the total of the health care components in each column.

Handling Problems Identifying Actual Costs for Each Column and for Individual Optional Supplemental Benefits

Some organizations may not be able to identify the share of the base-period reinsurance recoveries, costs of administration, reinsurance premiums, and additional revenues that should be entered on lines 23, 25, 26 and 27 of columns b, c, and d and that should be allocated to individual Optional Supplemental Benefits in column e. You can use the following approach to deal with such a situation.

Using costs of administration as an example, determine how much of your administration cost is related directly to the package of benefits offered to the enrollees of the M+C plan you are pricing. Then you can compute the ratio of total costs of administration to the sum of direct medical care for Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, and Optional Supplemental Benefits (columns b, c, d, and e). Worksheet B computes a subtotal for direct medical costs for columns b, c, and d. You will have to compute the direct medical costs for Optional Supplemental Benefits on a back-up schedule. Apply the ratio (percentage change) you compute to the subtotal direct medical costs shown on line 22 for columns b, c, and d. Enter those values on line 25 in the appropriate column. In addition, increase direct medical costs for each of your individual Optional Supplemental Benefits by the same percentage. Include a schedule with all your computations when you submit your ACR.

Use the procedure described in the previous paragraph if your organization cannot identify the share of additional revenue that should be entered on line 27 columns b, c, and d and that should be allocated to individual Optional Supplemental Benefits in column e.

Line 29 and Line 30

Medicare entries for lines 29 and line 30 will *not* be handled as described above in the instructions for lines 1 through 28. Show all amounts collected for Optional Supplemental

Benefits in the base year on line 29 in column e of this worksheet, even though the benefit may be in a different statutory benefit category for the contract year.

Line 29—Total Revenue. Enter, in column a, the per-member, per-month amounts (in dollars and cents) of total revenue collected in the form of cost sharing and premiums from all Medicare enrollees electing the M+C plan (or paid on their behalf, such as from employer groups) for Medicare-Covered Benefits, Additional Benefits, and Mandatory Supplemental Benefits. In addition, include the CMS PMPM payment for the plan for the base period. Enter the corresponding amount for Optional Supplemental Benefits on line 29, column e. Report amounts on an accrual basis and include all sums collected from enrollees by the M+C organization and/or any provider that furnished a benefit covered by the M+C plan.

Line 30—Enrolled member-months. Enter in column b the total number of enrolled-member-months for the plan during the base period. One member-month is counted for each month during which a person is enrolled in the plan. Enter in column e the total number of enrolled-member months for the optional supplemental benefits offered during the base period.

Chapter 5. Worksheet B1—Base-Period Financial Data

Worksheet B1 provides CMS with key financial information about M+C organizations. The indicators on the worksheet will be used to measure an organization's performance and financial health over several periods and against other M+C organizations with similar characteristics (e.g., size, geographic location). The indicators alone do not necessarily signal whether an M+C organization is going to go insolvent; they simply provide a way of evaluating the organization's financial condition and performance at a point in time. This worksheet also will be used for desk review purposes.

NOTE—Even though you must compile Worksheet B1 data at the M+C organization level rather than at the plan level, please fill out Worksheet B1 in every Excel workbook you submit to CMS. Also, note that the worksheet will accept only numeric values in the cells requiring entries. If you make non-numeric entries, an error message will appear to prompt you to enter a numeric value.

Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type**, and **Plan ID** from Worksheet A.

Column a—Prior Period. The prior period is the calendar year before the beginning of the base period. The base period is the most recently ended calendar year before this ACR proposal is due. In other words, if this ACR proposal is due in 2003, the base period is 2002 and the prior period is calendar year 2001. Enter the values for lines 6–17 to two decimal places.

Column b—Base Period. Enter the values for lines 6–17 to two decimal places.

Column c—Change. The change is calculated automatically and represents base-period values less prior-year values. Users need make no entries; all the cells in the column are locked.

Column d—% Change. The percentage change is calculated automatically; it represents the change value divided by the prior period value. Users need make no entries; all the cells in this column are locked.

Use of Indicators

Line 1—Net worth (dollars). Net worth equals total assets minus total unsubordinated liabilities. This amount shows an organization's excess of assets over its liabilities. It indicates the value of the firm with respect to equity.

Line 2—Total revenue (dollars). This figure reveals how much revenue the organization generated from all of its business plus investment, interest, and aggregate (miscellaneous) income.

Line 3—Operating revenue (dollars). This figure reveals how much revenue the organization generated from its primary lines of business.

Line 4—Operating profit or loss (dollars). This value indicates the amount of money the organization has after covering its direct medical and administrative expenses for a particular period. It reveals how well the organization is covering all of its costs of operations.

Line 5—Net profit or loss (dollars). This value is simply the operating surplus (or deficit) after considering taxes and extraordinary costs.

Line 6—Medical expense ratio. This ratio reveals the percentage of the organization's premium revenue needed to meet its direct medical costs for a particular period.

Line 7—Administrative expense ratio. This ratio reveals the percentage of the organization's premium revenue needed to meet its administrative costs for a particular period.

Line 8—Overall expense ratio. This ratio reveals the percentage of the organization's premium revenue needed to meet its direct medical and administrative costs for a particular period.

Line 9—Operating profit margin. This ratio reveals the percentage return the organization achieved on its operations for a particular period. It measures how effectively an organization is performing with respect to its ability to cover its fixed and variable expenses. The higher the ratio, the better an organization's financial performance.

Line 10—Overall profit margin. This ratio reveals the percentage return the organization achieved on its operations for a particular period when taxes and any extraordinary expenses are taken into account. It measures how effectively an organization is performing with respect to its ability to cover its fixed and variable expenses, as well its tax liability. The higher the ratio, the better an organization's financial performance.

Line 11—Debt-to-service ratio. This ratio indicates how effectively the organization is meeting its annual principal and interest charges on its outstanding debt.

Line 12—Current ratio. This ratio measures an organization's ability to meet its short-term liabilities with its current base of short-term assets. The ratio is short-term assets divided by short-term liabilities. Specifically, an organization must be able to convert its short-term assets such as investments and premium receivables to cash to cover its liabilities as they come due. A thumbnail standard for a desirable current ratio is a ratio greater than 1-to-1 (meaning that an organization has short-term assets equal to or greater than short-term liabilities). However, a current ratio of less than 1-to-1 does not imply that an organization cannot meet its obligations as they come due. See line 13 below for a more extensive explanation.

Line 13—The sum of current assets and long-term bonds divided by current liabilities. This ratio takes into account the fact that many organizations move a good deal of their spare cash to longer-term assets, such as Treasury and blue-chip corporate bonds. Because organizations receive cash (premiums) up front, they have a period of time to invest in longer-term assets such as Treasury bonds, which generally offer a greater return than shorter-term instruments such as

certificates of deposit (CDs). Therefore, many organizations move their spare cash out of the short-term investments to take advantage of the higher return.

However, this has the effect of making an organization appear—from the current ratio analysis—as if it did not have adequate resources to meet short-term obligations. Thus, as the user of the financial statements, we must recognize that these longer-term bonds are valued at the current market price and are extremely liquid. They can be converted to cash to cover short-term obligations as easily as the short-term investments and thus should be taken into consideration when measuring an organization's ability to meet short-term obligations as they come due.

Line 14—Days of cash on hand. This measure is the average number of days of cash an organization currently maintains on hand with respect to its current direct medical and administrative costs. It reveals the number of days the organization is able to cover operating expenses with its current cash on hand. Specifically, this yardstick allows one to better evaluate the organization's cash management policy—which directly reflects the organization's ability to immediately meet its obligations as they come due without the need to liquidate any investments. All other things being equal, a rising ratio is considered positive (it signifies increasing liquidity).

Line 15—Cash-to-claims-payable ratio. This ratio indicates the organization's ability to pay off (cover) its health, medical, and accounts payable with its available cash and cash equivalents.

Line 16—Days in premiums receivable. This measures the amount of premium revenue (measured in terms of days) due to the organization from the members. Additionally, it measures the organization's ability to convert its receivables to cash. If the organization's figure for days in premiums receivable is getting higher (more and more days of premiums receivable), the organization may be having difficulty converting the receivables to cash and could encounter future liquidity problems.

Line 17—Days in unpaid claims. This ratio indicates the number of days of claims an organization owes its members. This ratio is useful for determining whether an organization is meeting its health and medical liabilities effectively and efficiently (in a timely manner). An upward trend in this figure could indicate that the organization is becoming less able to meet its obligations as they come due (that is, the organization's liquidity is decreasing).

Formulas for Indicators

Line 1—Net worth equals total assets minus liabilities.

Line 2—Total revenue is self-explanatory.

Line 3—Operating revenue equals total revenue less revenue from investments, interest, and other miscellaneous sources, plus co-payments.

Line 4—Operating profit or loss equals operating revenue less the sum of direct medical costs and administrative costs.

Line 5—Net profit or loss equals total revenue less direct medical costs less administrative costs less taxes and extraordinary expenses.

Line 6—Medical expense ratio equals medical and hospital expenses divided by operating revenue.

Line 7—Administrative expense ratio equals administrative costs divided by operating revenue.

Line 8—Overall expense ratio equals direct medical costs plus administrative costs divided by operating revenue.

Line 9—Operating profit margin equals operating revenue minus direct medical and administrative costs, divided by operating revenue.

Line 10—Overall profit margin equals total revenue minus direct medical costs, administrative costs, taxes, and extraordinary expenses, all divided by total revenue.

Line 11—Debt-to-service ratio equals the sum total of net income, provision for income taxes, interest expense, and depreciation, divided by the sum of interest expenses and current loans and notes payable.

Line 12—Current ratio equals current assets divided by current liabilities.

Line 13—The sum of current assets plus long-term bonds divided by current liabilities is self-explanatory.

Line 14—Days of cash on hand is computed under the following formula: cash + short-term investments)/([total medical and hospital expenses plus total administrative expenses]/365).

Line 15—Cash-to-claims-payable ratio equals the sum of cash and cash equivalents, divided by claims payable.

Line 16—Days in premiums receivable equals premiums receivable divided by (total premium revenue [commercial, Medicare, and Medicaid] plus fee-for-service revenue, divided by 365).

Line 17—Days in unpaid claims equals claims payable divided by (total medical and hospital expenses, divided by 365).

Chapter 6. Worksheet C—Premiums & Cost Sharing for the Standard Benefit Package

Worksheet C reflects premiums and cost sharing that the M+C organization intends to charge per member, per month for the M+C plan priced by this ACR. The amounts placed on this worksheet are limited by the amounts calculated on Worksheet E for Medicare enrollees.

Multiple Plans Have Different Premiums and Cost Sharing

In a given service area, you can offer multiple M+C plans, each with its own premium and cost-sharing structure. In fact, an M+C plan can have only one plan premium and cost-sharing structure. If you want to vary a plan's premium and/or its cost-sharing structure, you need to create a separate plan and submit an ACRP for it.

> ***EXCEPTION***—If your organization segments the service area of a plan, each segment can have its own unique premium and cost sharing requirements. A segment cannot be smaller than a payment area (e.g., county, parish). Submit a separate ACRP for each segment.

ACR Values Needed for All Cost Sharing

Please include a separate ACR value for every cost-sharing amount in the PBP. CMS reviewers will question any ACR that does not contain cost-sharing values per member, per month that correspond to cost sharing in the PBP. Please ensure that all ACR entries reflect the correct health care component (line) and the correct statutory benefit category (column) in a manner consistent with the PBP.

No Grouping of Entries on Worksheet C

While CMS has given approval to group costs of certain health care components (lines) on Worksheets B and D (see the 2004 Call Letter and the 2004 ACR Transmittal Instructions, organizations cannot group cost sharing in either lines or columns of this worksheet.

Format of Entries

Please note the following conventions with respect to entries on Worksheet C:

- Enter premiums and the ACR value for any items of cost sharing as positive values.

- Leave cells blank to signify that the PBP has no cost sharing corresponding to the Worksheet C cell or that the plan has no premium.

- Do not enter zero, negative values, or text entries (e.g., "NA.") on the worksheet.

To ensure that cost-sharing amounts are properly recorded on Worksheet C of the ACR, please use as many decimal places as necessary for such entries. For example, do not round off a cost-sharing entry of $0.0005 to $0.00. Instead, enter $0.0005 in the appropriate cell. Even though the worksheet will round that amount to $0.00, the actual value will be recorded in the ACR database and will be used to verify that ACRs have cost-sharing entries that correspond to PBP cost sharing. However, enter premiums in dollars and cents using only two digits after the decimal point.

Coordinated Care Plan Limits

Premiums and cost sharing for the basic benefit package are limited to the ACR value of Medicare deductibles and coinsurance (as shown on Worksheet A). In addition, premiums and cost sharing charged to Medicare enrollees in such plans are limited to the ACR value of the benefit or group of benefits.

Besides the normal ACR limitations on total charges for a coordinated care M+C plan, there is an additional limit on premiums and cost sharing for Part A benefits offered to remaining Part B-only Medicare enrollees. The limit on Part B-only plan premiums and cost sharing for Part A services is discussed in the section on Worksheet C1.

Private Fee-for-Service Plan Limits

The ACR form does not regulate premiums charged by an M+C PFFS plan. However, cost sharing charged to Medicare enrollees in such plans is limited to

- the ACR value of Medicare deductibles and coinsurance (as shown on Worksheet A) and

- the ACR value of the benefit or group of benefits.

Line-by-Line Instructions

The following paragraphs provide detailed instructions for completing Worksheet C.

Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Line 1 Through Line 19

Enter on lines 1 through 19 the cost sharing in dollars and cents per member, per month for every benefit subject to cost sharing in the PBP. Use the same line and column location in the ACR that you used for the benefit in the PBP. The PBP for any plan may have cost sharing identified in a note section as well as in individual data entry boxes. Please do not forget to include on Worksheet C the PMPM equivalents of cost sharing identified only in PBP note fields.

> ***Special Treatment of Facility Fees***
>
> See the 2004 Call Letter. If a facility fee might apply to another health care component line item or service on Worksheet C, then you will need to disaggregate that cost sharing and show it on the line item related to that specific health care component or service. For instance, if an outpatient hospital facility fee might apply to a routine mammogram, you should show that cost sharing on line 14h and not on line 9a. The M+CO will need to show the calculation for facility fees and any other cost sharing related to mammograms separately in the ACR back-up material.

The PBP permits assignment of deductibles to benefits at levels ranging from plan-wide to individual health care sub-components. ACR amounts for deductibles at the various benefit levels should be handled as follows:

- Plan-Level Deductibles—Enter ACR amounts for plan-level deductibles (i.e., deductibles that apply to all benefits of a plan) on line 13ded of the worksheet. The organization should use its best estimates in allocating the plan-level deductible amounts to the correct statutory benefit categories.

- Other Deductibles—You can aggregate ACR amounts for deductibles that apply to certain health care components and sub-components on the appropriate health component line unless your organization wishes to allocate the amounts to sub-components. Enter ACR amounts for deductibles for specific health care sub-components on the same sub-component line used in the PBP. In both cases, organizations should assign the ACR amounts to the same statutory benefit category used in the PBP. If the deductible cuts across more than one statutory benefit category, organizations should use their best judgment to allocate the deductible costs to the correct category. In the latter case, if Medicare-Covered Benefits is one of the categories, assume that those benefits are used first.

Use line 19 to record the costs of your POS benefit, if you have one. Only organizations pricing HMOPOS plans and non-M+C plans can use line 19.

Many cells in column a are grayed out because the health care components or sub-components are not Medicare-Covered Benefits.

Line 20 Through Line 27

Enter on line 20 and line 21, as appropriate, any expected revenue from enrollees for cost sharing related to benefits for which original Medicare would be the secondary payer.

Lines 22, 23, and 24 are not used on this form.

Line 25 computes the individual sums of column a, b, and c for lines 1 through 21. The cells for line 25 are locked.

Fill in columns a and c, line 26 to reflect the premiums expected to be charged to Medicare enrollees for basic benefits (columns a and b), and to Medicare enrollees for Mandatory Supplemental Benefits (column c).

Line 27 computes the total charges (premiums and cost sharing) for each statutory benefit category. The cells are locked.

Column d

Column d computes the sum of corresponding lines in columns a, b, and c. The cells in column d are locked.

Chapter 7. Worksheet C1—Part B-Only Maximum Charge for Part A Benefits

Worksheet C1 is required for Part B-only plans. It is not relevant to Part A/B plans.

As stated in the discussion of Worksheet C, there is a limit on the maximum amount that can be charged (in terms of premiums and cost sharing) for certain benefits offered to remaining Part B-only Medicare enrollees. An M+C organization may choose to include benefits equivalent to Medicare benefits covered under Part A (inpatient hospital benefits, skilled nursing benefits, etc.) as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. The maximum that can be charged for the equivalent Part A benefits is the lesser of

- the ACR value of Part A benefits;
- the sum of the APR for Part A benefits, the actuarial value of Medicare's Part A deductible and coinsurance, and the ACR value of Medicare Part A COB for working aged; or
- the sum of the amount Medicare would charge for Part A benefits to individuals who otherwise do not qualify for Part A coverage and the actuarial value of Part A deductible and coinsurance.

Worksheet C1 is provided to calculate the limit on Part B-only plan charges for Part A services. **The amount you enter on line 12 of Worksheet C1 also must be included on Worksheet C.** As stated above, the Part A benefits offered in a Part B-only plan can be classified only as Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits. Please note that Part A benefits cannot be classified as Medicare-Covered in a Part B-only plan.

The worksheet requires you to enter four values for Part B-only plans. Those values should be entered on lines 1, 3, 5, and 12. None of the values in the four cells can be negative. (Those four cells will be locked if the enrollee type is Part A/B.) The worksheet calculates or is pre-populated with the required values for lines 4, 6, 8, 9, 10, and 11. The enrollee type at the top of the form is imported from Worksheet A. The following paragraphs provide detailed instructions for completing Worksheet C1.

Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Lines 1, 3, 5, and 12

The following paragraphs provide line-by-line instructions for completing Worksheet C1. The worksheet grays out lines 1, 3, 5, and 12 for all plans with enrollee types other than Part B-only.

Line 1. Enter on line 1, column b the ACR value of Part A benefits that your plan provides. If your Part B-only plan provides all Part A benefits and you have a plan of the same type in the same service area that covers Part A/B enrollees, the required ACR value is the difference between the ACRs for the two plans.

Line 3. Enter on line 3, column a the APR value of Part A benefits that your plan provides. If your Part B-only plan provides all Part A benefits and you have a plan of the same type in the same service area that covers Part A/B enrollees, the required APR value is the difference between the APRs for the two plans.

Line 5. Calculate the projected ACR value of Medicare Part A coordination of benefits for your projected working aged population. The value represents an estimate of the amount that you are entitled to collect from third-party payers (e.g., an enrollee's auto insurance company) when Medicare is the secondary payer for a given health care benefit.

Line 12. Enter your proposed charge to Part B-only enrollees for Part A benefits in this plan. Line 12, column b must be less than or equal to line 11. (Note that the cell on line 12, column b will turn red if that is not the case.) If you charge less than the maximum allowable, show the difference on Worksheet D, line 27ev1. Use the Additional Benefits column, the Mandatory Supplemental Benefits column, or both depending on the classification of benefits in this plan. If the plan offers both categories of benefits, allocate the amount on line 12 to both categories.

> ***REMINDER***—Include any amount on line 12 of this worksheet in the appropriate cells of Worksheet C.

Chapter 8. Worksheet D—Expected Cost and Variation for the Standard Benefit Package

Worksheet D serves two purposes. First, it calculates and displays the total expected costs in dollars per member, per month for each health care component under three of the four statutory benefit categories (i.e., Medicare-Covered Benefits, Additional Benefits, and Mandatory Supplemental Benefits). Second, Worksheet D is the vehicle for reflecting any expected variations from trended values of per-member, per-month costs for health care components in those three categories.

The following sections provide general instructions for and information about the worksheet.

Trended Values

The worksheet computes **trended values** for individual health care components in three columns (a, c, and e), thus providing one trend computation for all of the statutory benefit categories except for Optional Supplemental Benefits. Trended values for Optional Supplemental Benefits appear on Worksheet F.

The trended value for the health care components of Medicare direct medical costs is the base-period value of the component reported on Worksheet B adjusted by the direct medical care trend from Worksheet A. The trended value for administration costs is the base-period value of administration reported on Worksheet B adjusted by the administration trend from Worksheet A. The trended value for the total is the base-period value of Medicare total costs reported on Worksheet B adjusted by the non-Medicare trend for collections from enrollees/initial rate from Worksheet A. The trended value for additional revenue is the result of subtracting the direct medical care subtotal (line 24), administration (line 25), and reinsurance premium (line 26) from the total trended value (line 28).

If organizations did not have non-Medicare enrollees in the base period and/or do not expect to have them in the contract-year, initial rates cannot be computed. In that case, there will be no entries in columns a, c, and e. Similarly, no entries will appear in those columns if the plan did not incur any Medicare costs in the base period.

If trended values are inconsistent with you business plan, make adjustments to them so that the adjusted values (described below) are consistent with it.

Adjusted Values

The **adjusted values** in columns b, d, and f, reflect the sum of any expected variations (as described below) recorded on a given line and the trended value on the same line in the column on the left. For example, the adjusted value for Medicare-covered home health benefits (line 6,

column b) is the trended value on the same line under column a plus the expected variation on line 6, column b that you have entered on Worksheet D.

If an organization believes that the trend in non-Medicare experience is appropriate for each corresponding Medicare category (that is, medical benefit, administration, additional revenue, and reinsurance), then the adjusted values would equal the trended values. Otherwise, the organization should include the appropriate expected variation entries that produce the projected adjusted values.

Adjusted values should be consistent with your business plan.

Expected Variations

Expected variation entries serve several purposes. These include adjusting trended values and reporting contract year data when trended values are unavailable. This section discusses and provides guidance on the various types of expected variation entries. In addition to complying with the guidance in this chapter, **each expected variation entry also should follow all the rules for reporting data on Worksheet B**. For example,

- Do not reduce direct medical costs by cost-sharing amounts collected from enrollees (i.e., co-payments, coinsurance, and deductibles), regardless of who collects it. In other words, report total direct medical costs on Worksheet D as you did on Worksheet B.

- Show all projected reinsurance recoveries on line 23 (as an offset to direct medical costs) in the appropriate columns

- Show the amounts that could have been collected for COB on lines 20 and 21.

Refer to Chapter 5 of these instructions and the definitions in Chapter 8 of the MMC Manual for more about reporting cost data on the ACR in general and on Worksheet B specifically.

Examples of Expected Variation Entries

The expected variation cells in Worksheet D allow you to incorporate information not accounted for in the base period. For example, if CMS adds another benefit to those covered under original Medicare for the period of the ACR, the cost of the new benefit would not be reflected in the base-period costs for a given plan. Therefore, an M+CO should use expected variation entries to make the ACR computation approximate more closely the cost that would be incurred for the Medicare population during the ACR period.

The expected variation cells also allow you to adjust trended values because the trend Worksheet A computed is inappropriate. The trend from Worksheet A would be inappropriate, for example, if you project that your Medicare costs will change at a different rate than your non-Medicare costs.

Expected variations will be needed on Worksheet D to adjust trended values for plans having a contract-year service area that is different from the base-period service area. This is consistent with the Worksheet B instructions that require base-period costs to reflect the plan's base-period service area.

In addition, the expected variation cells allow organizations to enter the 2004 data for any plan ACR that does not generate trended values. For example, M+C organizations offering M+C plans without non-Medicare enrollees in either or both the base period and the contract year, the trended value columns will be blank. The same is true for organizations without Medicare enrollees in the base period. As a result, such organizations must use the appropriate expected variation cell in Worksheet D (or Worksheet F for Optional Supplemental Benefits) to enter the expected contract-year cost for individual health care components. Similarly, organizations offering new benefits should use the expected variation cells to record the expected cost of those benefits for the contract year. Document such estimates clearly and develop them using appropriate projection techniques.

Furthermore, use the expected variation cells in Worksheet D to delete the trended value costs for any base-year benefit not offered in the contract year. Moreover, as discussed later in this section, use the expected variation entries to disaggregate (i.e., apportion) trended values as necessary.

> ***REMINDER***—Worksheet B should include only entries properly accrued to the base period, and those entries must track to financial statements for that period **that comply with GAAP**.

Finally, M+C organizations should use this worksheet to adjust for any errors in the formulas built into the electronic ACR. Annotate the adjustments in a supplemental document as a "formula error," with the cell reference to identify which formula is in error.

No Grouping of Expected Variation Entries

Expected variation entries on Worksheet D or Worksheet F should be consistent with the PBP in terms of the classification by line and column. Even though you group data for various health care components on Worksheet B (see the 2004 Call Letter and ACR Transmittal Instructions), you should not group any related expected variations for various health care components on Worksheet D. In other words, if you are grouping data for health care components on Worksheet B, and if column c, Part I B of Worksheet A displays a trend, the trended values on Worksheet D also will be grouped. You are not required to disaggregate the trended values unless you need to adjust them. In that case, use the expected variation cells to display the 2004 total adjusted value for them.

The following example illustrates that point. Consider an M+C organization that groups costs of certain health care components on ACR Worksheet B. Assume that, in completing its ACR, the organization groups costs for preventive dental services (normally shown on line 16) together with the costs of preventive services on line 14 (preventive services) under the Mandatory Supplemental Benefits column. In addition, assume that:

- The combined trended value on of the 2 benefits on Worksheet D is $12 PMPM.
- The M+CO projects a total of both dental and preventive services of $14 PMPM.
- The $2 difference between the $14 PMPM projection and the trended value of $12 PMPM is $1 PMPM for line 14 and $1 PMPM for line 16.
- The M+CO projects the dental benefit to cost $5 PMPM in 2004.

In this case, enter $5 PMPM for the value of the dental benefit on line 16ev. In addition, enter of line 14ev the sum of the desired adjustments for both dental and preventive services less the $5 total adjusted value of the dental benefit. The sum of the adjusted values on line 14 and line 16 will then equal the projected amount of $14 PMPM. The illustrative entries appear in the following table.

Line #	Health Care Component	Trended Value	Adjusted Value
		e	f
14	Preventive Services	12.00	9.00
14ev	Expected Variation		(3.00)
16	Dental		5.00
16ev	Expected Variation		5.00

If your plan does not offer in 2004 one of the benefits grouped on Worksheet B with other benefits, leave the Worksheet D expected variation cell for the cancelled benefit blank. Include the required negative adjustment to remove the trended value for 2004 on the expected variation line that displays the trended 2004 value of the grouped benefits.

Finally, you should make every effort to make the content of each health care component on Worksheet D consistent with the classification used in the PBP, even if you have grouped on Worksheet B. The reason is that CMS will review Worksheet C entries and attempt to track entries from Worksheet C to Worksheet D. Where premium and cost sharing information appear in a specific health care component on Worksheet C and there is no corresponding entry on worksheet D, CMS will ask for substantiation or look for back-up materials to substantiate the entry on Worksheet C. The ultimate affect of grouping on Worksheet D is to de-automate this portion of the ACR.

Format of Expected Variation Entries

To ensure that expected variations are properly recorded on Worksheet D, use as many decimal places as necessary. For example, do not round off an expected value entry of $0.0005 to $0.00. Instead, enter $0.0005 in the appropriate cell. The worksheet will round (and truncate) all entries

of less than 1/2 cent per member, per month to $0.00 (with the correct sign), but the actual value that you enter will be stored in the ACR database. Blank entries signify that no adjustments are necessary to the related trended value for a given statutory category. Therefore, leave cells blank if no adjustments are necessary to a particular trended value; the worksheet will not let users enter $0.00.

The worksheet will allow negative entries, however, it will not allow users to enter negative values large enough to make corresponding health care components (or related sub-components) negative on lines 1 through 19 and line 23 of the Medicare-Covered, Additional, and Mandatory Supplemental benefit categories.

The worksheet will not allow text entries (e.g., "N/A").

Making Expected Variation Entries

Record expected variations on the expected variation line for each health care component under the appropriate statutory benefit category. As described above, the expected variations will be added to trended values (i.e., the same statutory benefit category).

Justification of Expected Variations

Justify in writing all entries in expected variation cells in Worksheet D (except for negative entries on line 27ev2). Please submit such justifications with the paper copy of your ACR. Naturally, any justification provided should be in enough detail to fully explain the specific variation at issue. Some justifications can be very brief. For example, merely stating that an expected variation was needed to eliminate the costs in the worksheet for a previously offered benefit that is being dropped in the contract year would be adequate. Other justifications, such as ones pertaining to the costs of a new benefit and positive entries on line 27, need to be more detailed and must include all computations.

Please pay particular attention to the justification of expected variation entries that you use to adjust trended values *because you believe that your base period experience is not fully credible*. In that case, the data supporting your expected variation entries will supplement the experience of the plan. CMS recognizes that in the projection of medical costs there are acceptable actuarial techniques supplementing actual plan experience with other data sources. If you use such blending techniques in the projection of 2004 medical costs, include in the exhibits supporting Worksheet D

- a description of methodology used, including justification for the methodology and data sources,

- a demonstration that appropriate adjustments have been made to the source data to reflect the demographic and risk characteristics of the plan enrollees, and the effects of plan design, such as cost sharing requirements, and

- a description of the blending methodology used in prior ACR submissions, and if it differs from that used in the current submission, a description of the differences and rationale for the change in approach.

Guidance on appropriate techniques for blending actual plan experience with other sources can be found in the Actuarial Standard of Practice No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages.* The document can be found on the American Academy of Actuaries' website at http://www.actuary.org/.

Line-by-Line Instructions

This section provides detailed instructions on completing Worksheet D.

Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Line 1 through Line 28

General

Lines 1 through 28 (without the suffix ev) show trended values for Medicare-Covered Benefits, Additional Health Care Benefits, and Mandatory Supplemental Benefits in columns a, c, and e respectively. As noted below, a few cells are locked.

Lines 1 through 28 (without the suffix ev) also show the total adjusted values for Medicare-Covered Benefits, Additional Health Care Benefits, and Mandatory Supplemental Benefits in columns b, d, and f respectively

You cannot enter values on lines 1 through 28 (without the suffix ev). The cells are locked.

Lines 1 through 28 with the suffix ev are available for entering expected variations. When you enter an expected variation in columns b, d, or f, the worksheet automatically adds (or subtracts when appropriate) the expected variation to the corresponding trended value in the previous column. The worksheet also displays the new adjusted value in the same column on the corresponding line without the suffix ev.

Line 1 through Line 19

The trended values on lines 1 through 18 of columns a, c, and e and line 19 of columns c and e reflect the product of the trend value (from Worksheet A, Part I B, column c, line 2) for direct medical care without reinsurance recoveries and the individual base-period values for each item on lines 1 through 19 of Worksheet B.

POS is not a Medicare Covered benefit; therefore, the cells in column a and column b of line 19 are blocked.

Whenever cells on line 1 through line 19 in columns a, c, and e turn yellow, please enter the sub-component line numbers from Worksheet C for every sub-component covered by the particular expected variation entry. For example, if you enter an expected variation on line 14 (Preventive Services) of column b on this worksheet, and the variation covers both immunizations and diabetes monitoring, enter 14b and 14i, separated by a comma, in column a.

Line 20—COB-Working Medicare

The trended value on line 20 of column a reflects the product of the trend value (from Worksheet A, Part I B, column c, line 2) for direct medical care without reinsurance recoveries and the individual base-period value for COB-Working Medicare on Worksheet B.

Columns c through f for line 20 are blocked.

Line 21—COB-Other

The trended values on line 21 of columns a, c, and e reflects the product of the trend value (from Worksheet A, Part I B, column c, line 2) for direct medical care without reinsurance recoveries and the individual base-period values for COB-Other on Worksheet B.

Line 22—Subtotal

Line 22 is the subtotal of the preceding lines (without the suffix ev) in each column.

Line 23—Reinsurance Recoveries

The trended values on line 23 of columns a, c, and e reflect the product of the trend value (from Worksheet A, Part I B, column c, line 3) for direct medical care without reinsurance recoveries and the individual base-period values for reinsurance recoveries on Worksheet B.

Line 24—Direct Medical Care

Line 24 displays the total of direct medical care in each column. It sums lines 22 and 23.

Line 25—Administration

The trended values on line 25 of columns a, c, and e reflect the product of the trend value (from Worksheet A, Part I B, column c, line 4) for administration and the individual base-period values for administration on Worksheet B.

Line 26—Reinsurance Premium

The trended values on line 26 of columns a, c, and e reflect the product of the trend value (from Worksheet A, Part I B, column c, line 5) for reinsurance premium and the individual base-period values for reinsurance premium on Worksheet B.

Line 27—Additional Revenue

The worksheet calculates trended values for additional revenues differently than for other lines. Worksheet A, Part IB has no trend value for additional revenues. Therefore, the trended value for additional revenues in line 27 of columns a, c, and e is the difference between the trended values on line 28 for one of those columns and the sum of the trended amounts for direct medical costs, administration, and reinsurance premium in the same column. The next table provides an example of the calculation of additional revenues for Medicare-Covered benefits:

Line #	Health Care Component	Trended Value Medicare Covered Benefits
28	Total	500.00
Less		
24	Direct Medical Costs	430.00
25	Administration	40.00
26	Reinsurance Premium	10.00
Equals:		
27	Additional Revenues	20.00

Enter expected variations as needed for additional revenue on the components of line 27 (lines 27ev1, 27ev2, and 27ev3), columns b, d, and f. Generally, those cells are used to

- make optional adjustments to correct errors on Worksheet E (NOTE: As discussed in the next subsection and in the chapter on Worksheet E, adjusting additional revenues is only one of the options you have for correcting errors on Worksheet E);
- reflect State-mandated requirements (e.g., financial requirements) that affect your M+C plan; and/or
- make the residual additional revenue values in columns a, c, and e of this worksheet more precise.

Correcting Error Messages on Worksheet E

Line 27ev1 is one of several options you can use to make adjustments to eliminate errors on Worksheet E, lines 19, 23, and/or 29. You also can correct the errors on Worksheet E, lines 19, 23, and/or 29 by correcting errors elsewhere in the ACR workbook or by changing Worksheet C to modify the charges to enrollees.

Use line 27ev2 **only** when your adjusted ACR (Worksheet E, line 8) exceeds your APR (Worksheet E, line 1) and you have corrected all errors in other worksheets. For example, if the adjusted ACR on line 8 is greater than the APR on line 1, "ERROR" will appear on line 9. In that case, enter an adjustment on Worksheet D, column b, line 27ev2 to reduce additional revenues

(thereby reducing the adjusted ACR) enough to equalize the adjusted ACR and the APR. The amount of the required adjustment is displayed in Worksheet E column b, line 9.

Reflecting State Mandates

Use expected variation cells on line 27ev3 to reflect State mandates (e.g., financial requirements) affecting your plan. For example, use the line to record State-mandated transfers to reserve accounts.

Improving the Precision of Additional Revenue Values

With respect to improving the precision of additional revenue values on Worksheet D, consider that a loss incurred in a prior period can produce a loss in the ACR period based on the trended value computation. However, you cannot carry forward to the contract year losses realized in the base period. Therefore, you would need to adjust additional revenue for the ACR contract year. Use line 27ev1 for such adjustments.

Documentation Requirements

As indicated earlier in this chapter, justifications such as ones pertaining to positive entries on line 27 need to be detailed and must include all computations. Please explain fully your need for any increase in the trended value for additional revenues.

Line 28—Total

The worksheet computes the trended values in columns a, c, and e by multiplying the collections/initial rate trend (from Worksheet A, Part I B, column c, line 1) by the values in columns b, c, and d on line 28 of Worksheet B.

Column g

Column g shows the adjusted value of total benefits, which is the contract-year value of all health care components including administration and additional revenue. Column g sums the values on each corresponding line of columns b, d, and f. Make no entries in column g; the cells are locked.

Chapter 9. Worksheet E—Adjusted Community Rate for the Standard Benefit Package

Worksheet E calculates the ACR for the standard benefit package for the M+C plan you are pricing. All cells are locked; no user entries are needed. The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type**, and **Plan ID** from Worksheet A.

Descriptions for other automatically calculated cells follow. Worksheet E has been programmed to provide error messages to help you resolve problems that could interfere with uploading of your ACR to HPMS or could cause CMS reviewers to question your ACR. This chapter discusses many possible errors. CMS can provide assistance to help you resolve errors not discussed in this chapter.

Unless otherwise noted, all lines relate to column a.

Line 1—Average Payment Rate. The line displays the APR from Worksheet A, Part I A, column a, line 8.

Line 2—Direct Medical Care. The line displays the direct medical care costs of Medicare-Covered Benefits from Worksheet D, column b, line 24.

Line 3—Administration. The line displays the cost of administration for Medicare-Covered Benefits from Worksheet D, column b, line 25.

Line 4—Reinsurance Premium. The line displays the reinsurance premium from Worksheet D, column b, line 26.

Line 5—Additional Revenues. The line displays the additional revenues related to Medicare-Covered Benefits from Worksheet D, column b, line 27.

Line 6—Adjusted Community Rate. The line sums lines 2 through 5.

Line 7—Medicare Deductible and Coinsurance. The line displays the actuarial value of Medicare's deductible and coinsurance from Worksheet A, Part I A, column a, line 12.

NOTE—The amount on line 7 includes the actuarial value of Medicare's co-payment for psychiatric benefits.

Line 8—Adjusted ACR. The line subtracts the amount shown on line 7 from the ACR (line 6).

Line 9—Excess Amount. The line subtracts the adjusted ACR (line 8) from the APR (line 1).

If the remainder on line 9 is zero, you should not have any entry on line 12 and you should not have any contributions to a stabilization fund.

If the remainder is a positive value, you can use the excess amount shown on this line to fund; contributions to a stabilization fund, Additional Health Care Benefits, a reduction of plan enrollees' Medicare Part B premium, a reduction of the plan premium, and/or a reduction of plan cost sharing. Another option is to make adjustments (that you can justify) on Worksheet D to increase the plan ACR, thereby reducing the excess amount. Finally, you can combine all of the actions described in this paragraph. The only exception is that a plan cannot have withdrawals from and contributions to a stabilization fund during the same contract period.

Line 9 cannot be less than zero. If line 9 displays a negative number, an error message will appear in column a in lieu of the negative number. In that case, check for errors in other worksheets. Correct any errors you find. If you do not find any other errors, you can enter an adjustment on Worksheet D, column b, line 27ev2 to reduce additional revenues enough to equalize the adjusted ACR and APR. That adjustment is needed because losses in excess of any APR cannot be charged to beneficiaries. Please do not use line 27ev2 of Worksheet D for any purpose other than to equalize the adjusted ACR and APR when line 9 computes a negative number.

Line 9—column b shows the amount of any required adjustment needed in column a.

Line 10—Contributions or Withdrawals from Stabilization Fund copies the amount to be deposited in or withdrawn from a stabilization fund from Worksheet A, Part I A, line 9. CMS will change the monthly amount it will pay to the organization per Medicare enrollee by the amount on this line.

You will see an error message in column a if you enter a positive value (contribution to a stabilization fund) on line 10 that exceeds 15 percent of line 9. When an error message appears, line 10, column b will calculate and display 15 percent of line 9. Reduce the amount on Worksheet A, Part I A, line 9 to no more that 15 percent of line9 of this worksheet to correct the error.

Line 11—Adjusted Excess Amount subtracts from the excess amount (line 9) any contributions to a stabilization fund (line 10). If the amount on line 10 is negative (i.e., reflects a withdrawal from a stabilization fund), line 11 subtracts that amount, thereby increasing the excess amount.

If line 11 is zero, you should have no entry on line 12.

If the amount on line 11 is positive, refer to the description of line 9.

Line 11 cannot be less than zero. If line 9 is less than zero, the worksheet will not show any value on line 11.

Line 12—Amount Withheld for Part B Premium Reduction. The line displays the value shown on line 11 of Worksheet A, Part I A. Column a will display an error message if the value on line 12 exceeds the value on line 11 of Worksheet E. If an error message appears in column a, column b will compute and display the amount by which you must reduce line 11, column a of Worksheet A.

Line 13—Hospice Rate for Plans with Part A/B Enrollees. The line displays the result of subtracting line 12 from line 11.

If the amount on line 13 is positive, refer to the description of line 9.

Line **13** cannot be less than zero. If line 13 is less than zero, an error message will appear in the cell. If line 9 and line 13 are both less than zero, refer to the description of line 9. If line 9 is correct, you must adjust the amount in Worksheet A, Part I A, line 11. In that case, refer to the instructions for Worksheet A, Part I A, line 11.

NOTE—For plans covering Part A/B enrollees, line 13 is the hospice rate described in 42 CFR 422.266 (c).

Line 14—Direct Medical Care enters the direct medical care costs for Additional Health Care Benefits from Worksheet D, column d, line 24.

Line 15—Administration enters the costs of administration for Additional Health Care Benefits from Worksheet D, column d, line 25.

Line 16—Reinsurance Premium enters any reinsurance premium from Worksheet D, column d, line 26.

Line 17—Additional Revenue enters the additional revenue for Additional Health Care Benefits from Worksheet D, column d, line 27.

Line18—Total Additional Health Care Benefits sums lines 14 through 17. Additional Health Care Benefits cannot exceed the amount on line 11. If they do, an error message will appear in the cell. Make adjustments as needed. For example:

- Check for errors in base-period costs on Worksheet B, trend values on Worksheet A, and expected variation entries on Worksheet D. Make any required adjustments.
- Change the coverage of Additional Health Care Benefits and re-price them as appropriate.
- Adjust additional revenue on Worksheet D, using line 27ev1 in column b or column d. As indicated in the previous chapter, M+COs must justify entries on line 27ev1.

Line 19—Remaining Excess subtracts line 18 from line 13.

If the amount on line 19 is positive, refer to the description of line 9.

Line 20—Medicare Deductibles and Coinsurance enters the actuarial value of Medicare's deductible and coinsurance from Worksheet A, Part I A, column a, line 12. The amount is the same value displayed on line 7.

NOTE—The amount on line 20 includes the actuarial value of Medicare's co-payment for psychiatric benefits.

Line 21—Remaining Excess enters the amount from line 19. The worksheet will subtract this amount from line 20 to determine the ACR value of the amount that plan enrollees will be charged for plan premiums and cost sharing (or just cost sharing in the case of private-fee-for-service plans). The value on line 21 must not exceed the value shown on line 20.

Line 22—Amount to be Charged to Enrollees subtracts line 21 from line 20. The remainder represents the amount that an M+C organization can charge its Medicare enrollees for Medicare-Covered Benefits and Additional Benefits (including all payments in the form of premiums, deductibles, coinsurance, and co-payments) consistent with the other entries on the ACR.

Line 23—Projected Charges. Column a enters the total of all actual charges to the Medicare enrollee for Medicare-Covered Benefits and Additional Benefits. The worksheet sums the amounts found on Worksheet C, columns a and b, line 27.

If this amount does not equal the amount on line 22 above, an error message will appear in the cell. In that case, please take one or more of the following actions:

- Check for errors in base-period costs on Worksheet B, trend values on Worksheet A, and expected variation entries on Worksheet D. Make any required adjustments.
- Change the coverage of Additional Health Care Benefits, if any, and re-price them as appropriate.
- Adjust the ACR value of the charges (on Worksheet C) to the Medicare enrollee. (Remember to make corresponding adjustments to the enrollee charges in the PBP.)
- Adjust additional revenue on Worksheet D, using line 27ev1 in column b or column d. As indicated in the previous chapter, M+COs must justify entries on line 27ev1.

The amount of any required adjustment is shown on line 21, column b.

Line 24—Direct Medical Care enters the direct medical care cost of Mandatory Supplemental Benefits from Worksheet D, column f, line 24.

Line 25—Administration enters the cost of administration of Mandatory Supplemental Benefits from Worksheet D, column f, line 25.

Line 26—Reinsurance Premium enters any reinsurance premium for Mandatory Supplemental Benefits from Worksheet D, column f, line 26.

Line 27, Additional Revenue enters the additional revenue for Mandatory Supplemental Benefits from Worksheet D, column f, line 27.

Line 28—Total Mandatory Supplemental Benefits sums lines 24 through 27.

Line 29—Projected Charges. The cell in column a displays the total of all actual charges to the Medicare enrollee for Mandatory Supplemental Benefits. That amount appears on Worksheet C,

column c, line 27. If this amount does not equal the amount in column e, line 28, please take one or more of the following actions:

- Check for errors in base-period costs on Worksheet B, trend values on Worksheet A, and expected variation entries on Worksheet D. Make any required adjustments.
- Adjust the ACR value of the charges (on Worksheet C) to the Medicare enrollee. (Remember to make corresponding adjustments to the enrollee charges in the PBP.)
- Change the coverage of Mandatory Supplemental Benefits and re-price them as appropriate.
- Adjust additional revenue on Worksheet D, line 27ev1, column f. As indicated in the previous chapter, M+COs must justify entries on line 27ev1.

The amount of any required adjustment is shown on line 29, column b.

Line 30—Total Charges displays the sum of line 23 and line 29. That sum represents the total amount that the M+C organization can charge its Medicare enrollees (premiums and cost sharing) for the benefit package under the plan you are pricing.

Chapter 10 Worksheet F—Adjusted Community Rate, Premiums, and Cost Sharing for Optional Supplemental Benefits

Regulations at 42 CFR 422.310(a)(3) require M+C organizations to calculate a separate ACR for each optional supplemental benefit offered under a specific M+C plan. Worksheet F calculates those ACRs with data from other ACR worksheets. You can combine individual health care components under a single premium for marketing purposes; nevertheless, you must price each health care component in a group individually on Worksheet F. Thus, the maximum charge for a group (i.e., package) of health care components would be the sum of the maximum charges for all of the components.

> ***REMINDER***—Worksheet B should include only entries properly accrued to the base period, and those entries should track to financial statements for that period **that comply with GAAP**.

Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

Column a Through Column k

Column a—Optional Supplement Benefits. Pick the name of a health care component from the drop-down menu on each individual line from line 1 to line 30. The drop-down menu will appear when your cursor is on any of those lines. Any single health care component can appear in more than one package of Optional Supplemental Benefits. Only organizations pricing HMOPOS plans and non-M+C plans can select POS from the drop-down menu. If you *did not* select HMOPOS or non-M+C on Worksheet A, Part I A, line 5, the cells in column a of this worksheet will turn red if you select POS.

If you plan to offer more than one individual benefit, do not leave any blank cells in column a between your first and last entries. If you do, error messages will appear. Also, if you have a blank cell in column a and you try to enter data in other columns on that line, error messages will appear to prompt a correction.

Column b—Package ID. Enter an identification (ID) number to signify in which package of Optional Supplemental Benefits the benefit in column a will appear. Use 001 to identify the first package (or only package if you have just one package). Use whole numbers in sequence (e.g., 002, 003) to identify any additional packages of Optional Supplemental Benefits.

Column c—ACR before Adjustments. The worksheet will automatically enter an ACR value for 2004 for each individual optional supplemental benefit (health care component) in column a if data in Worksheets A and B support such a calculation. The ACR value for any specific health care component will represent the product of the 2-year trend value from line 1 of Worksheet A, Part I B and its value in column e of Worksheet B. If the ACR lacks a 2-year trend value, base-year data, or both for an individual benefit, column c will be blank.

Column d—Adjustments (Expected Variation). If the adjacent cell in column c is not blank, enter in column d any adjustment needed to make the trended value for 2004 more accurate. Explain the reason for the adjustment in your ACR back-up material.

If the adjacent cell in column c is blank, enter the 2004 ACR value for the benefit. Remember to include COB–Other receipts, costs of administration, and additional revenue with the expected variation for each benefit. Please provide detailed calculations supporting your estimates in the back-up material for your ACR. Be sure to break out the amounts for direct medical costs without reinsurance recoveries, reinsurance recoveries, administrative costs, reinsurance premiums, and additional revenue for each benefit.

You can make negative adjustment in column d; however, you cannot enter a negative adjustment large enough to generate zero or a negative amount in the same line of column e. If you make an "oversize" negative adjustment in column d, error messages will appear in the worksheet to prompt you to correct the error.

***NOTE*—**Please refer to the chapter on Worksheet D for a general discussion of expected variation entries. As indicated in that chapter, please make sure that each expected variation entry on this form follows the rules for expected variations as explained in the chapter on Worksheet D. In addition, expected variation entries should follow the rules for reporting data on Worksheet B. For example, make sure that the direct medical costs are not reduced by the value of cost sharing paid by or on behalf of plan enrollees. Refer to the chapter on Worksheet B and the definitions in Chapter 8 of the MMC Manual for more on the rules for reporting ACR data.

Column e—ACR (Total Projected Price). The worksheet enters the ACR (total projected price) for each individual optional supplemental benefit in column a. The ACR value is the sum of the values, if any, in column c (ACR before Adjustments) and column d (Adjustments).

The ACR for an optional supplemental benefit represents the amount you must charge (in terms of the total of cost sharing and premium) each beneficiary for that benefit. If you include that benefit in a package with other Optional Supplemental Benefits, the ACR is the benefit's share of the total package costs.

The amount shown on each line of column e should be the same as the amount on the corresponding line of column h (Total). If not, an error message will appear. In that case, check your pricing, cost sharing, and premium amounts for errors.

If the column e is zero or negative for any benefit in column a, the message "No Cost" will appear. In that case, enter cost values as appropriate or delete the benefit.

Column f—Cost Sharing. Enter the Medicare enrollee's cost sharing PMPM for the health care component shown in column a.

Column g—Premium. Enter the Medicare enrollee's premium PMPM for the health care component shown in column a.

Column h—Total. The worksheet enters the sum of columns f (Cost Sharing) and g (Premium) separately for each benefit shown in column a.

Columns e and h must display identical values. If they don't, error messages will appear in the upper right hand corner of the worksheet and in column h and column i. In that case, please take one or more of the following actions:

- Check for errors in base-period costs on Worksheet B, trend values on Worksheet A, and expected variation entries on Worksheet F. Make any required adjustments.
- Change the coverage of Optional Supplemental Benefits. Re-price them as appropriate.
- Adjust the ACR value of the charges (on Worksheet F) to the Medicare enrollee. (Remember to make corresponding adjustments to the enrollee charges in the PBP.)
- Adjust additional revenue on Worksheet F.

Column i—Adjustment Needed to Fix Error. Column i computes the dollar amount of the change you need to make to correct an error in one or more of the other columns. The value shown in each cell of column i relates to an error (or errors) in the same row. If you have made more than one apparent error, the value shown in column i will cover all errors. The value will change each time you enter a change on the corresponding row. The cell will become blank when the system no longer detects an error in the same row on the worksheet.

Column j—Package ID. Column j shows the package ID that corresponds to the package premium shown in the next column (column k).

Column k—Package Premium. Column k shows the total premiums PMPM for all packages of Optional Supplemental Benefits the plan offers.

Chapter 11. Worksheet G—Actuarial Review Sheet

Worksheet G displays various calculations using data from other ACR worksheets. CMS will use the calculations when reviewing your ACR. The worksheet is in the ACR workbook so that you can refer to it if CMS asks questions about the data underlying the calculations. All the cells are locked. You do not have to enter any data directly on Worksheet G.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0742. The time required to complete this information collection is estimated to average 95 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: Reports Clearance Officer, 7500 Security Boulevard, C5-14-03, Baltimore, Maryland 21244-1850.